LEARNING MOTIVATIONAL INTERVIEWING: A THEMATIC ANALYSIS EXPLORING HEALTH PROFESSIONALS' TRAINING EXPERIENCES

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A thesis submitted in partial fulfillment of the requirements for the degree of Professional Doctorate in Health Psychology

QUEEN MARGARET UNIVERSITY
2011

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Declaration

I declare that all the work included in this thesis is my own except where otherwise stated. No portion of this work has been, or will be submitted for any other degree or professional qualification.

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Acknowledgements

I would like to thank the School of Arts & Social Sciences, Queen Margaret University, and my supervisors: Dr. Joyce Willock, who helped me begin the Professional Doctorate in Health Psychology and this thesis; and Prof. Marie Reid, Dr Zoë Chouliara, and Dr Vivienne Chisholm who guided me to its completion. I am grateful to each for the encouragement, advice and support given. I also thank, Dr. Jane Kunkler, Lothian Pain Service, for the knowledge, professional and personal guidance, and the emotional support that she imparted and which can not be surpassed. In addition, I thank many staff members at Queen Margaret University, and especially Dr Michele Hipwell for her frequent support, and words of advice, and Dr. Chris McVittie for his suggestions and advice early in project. I would like to thank Dr Lorna Torrens whose comments on the review chapters of the thesis were invaluable. I am also grateful to Prof. Paul Flowers who found time in his busy schedule to review and comment on my analysis and an early draft of this report.

My gratitude goes to Nicola Stuckey and Dr Pete Littlewood, who provided me access to the participants, and to the health professionals who participated in this study, and without whom it would not have been possible – I hope I have done you justice.

Finally, I would like to say a huge thank you to my best friend and partner Jennifer, without whom this would not have been possible. Thanks to Fiona for her peer support, friendship and for sharing this sometimes arduous journey along with much laughter. Thank you too to all my friends and colleagues who frequently listened, supported and accompanied me throughout this journey, and to my loyal students who have provided the financial means for me to study over the last 8 years.

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Abbreviations

AsSET	Astley ainslie pSychological Skills and Education Training
BCC	Behaviour Change Counselling
CBT	Cognitive Behaviour Therapy
CMC	Computer-mediated communication
DPR	Declarative Procedural Reflective Model
E-mail	Electronic Mailing
FTF	Face-to-face
GT	Grounded Theory
IPA	Interpretative Phenomenological Analysis
LAN	Local Area Network
MI	Motivational Interviewing
MINT	Motivational Interviewing Network of Trainers
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
OARS	Active listening techniques – open questioning, affirming, reflecting and summarising
SIGN	The Scottish Intercollegiate Guidelines Network
SMS	Substance Misuse Service
SPC	Self-perception of competence
TA	Thematic Analysis
ZPD	Zone of proximal development

Abstract

Aims: This study explores how training in Motivational Interviewing (MI) is experienced and given meaning by 23 multi-disciplinary health professionals. It uses a qualitative interpretative thematic analysis, aiming to identify key elements in the process of learning and applying MI consultation skills in their clinical practice.

Setting/method: The health professionals were recruited from two MI training programmes in Scotland, they worked in either cardiac rehabilitation or substance abuse settings. The time elapsed since training workshops for each participant varied between 4 months and three years. Data were collected electronically via E-mail and participants completed either an open-ended questionnaire or a reflective diary.

Results: The data obtained via these data collection methods was rich and informative and it revealed several key experiences and factors for successfully learning and applying MI. MI training is an emotional experience before, during and after workshops. Learning MI is challenging, and a shift in professional identity with clinicians feeling temporarily deskilled is a common experience. Practice with real clients, supervision and other reflective practices, facilitate and are crucial for learning effective MI skills, and developing competency can take years. MI is also seen as powerful and concerns about sensitive disclosure may arise, that may inhibit practicing MI skills. Clinicians also find it challenging to adjust to new ways of thinking and behaving, and often revert to the more traditional authoritarian expert approach they are used to. When clinicians become more competent and skills are consolidated, they experience an increased sense of professionalism and confidence in their ability to facilitate clients in making informed choices about their health and about illness management. They also experience less stress and dissatisfaction with resistant clients. Several additional facilitators and barriers are discussed.

Conclusion: The study raises implications for MI training theory and practice and adult learning theories. The findings suggest that learning MI is emotionally demanding and tiring, and that building MI competency requires a considerable amount of time and resource. This needs to be taken into account, when planning and implementing MI training programmes if these are to succeed in embedding MI culture in health services.

Key words: learning motivational interviewing, motivational interviewing training, Thematic Analysis

Preface

This thesis uses Thematic Analysis to explore experiences of learning Motivational Interviewing (MI) from the perspectives of multi-disciplinary health professionals who have a lived experience of participating in MI training programmes.

It begins by describing the background to the study. Chapter 1 sets the study in context and provides an overview of the rationale behind its conception and design. The study's aims are outlined and the specific research questions listed. A brief description of the participants and an overview of the qualitative methodology used are also provided. In Chapter 2 the MI approach is outlined before an overview of the extant MI training literature is discussed. Finally a brief discussion of some of the theories on the adoption and dissemination of new behavioural technologies will be presented.

Next methodological aspects of the study are outlined. Chapter 3 extends the rationale for using a qualitative and in particular a TA approach. In order to contextualise experiences and the study's findings, the chapter then provides some background about the researcher, and describes the participants, and the training courses and settings from which they were recruited in some detail. The electronic written data collection methods are then described before the data collection procedures are outlined. Finally, the chapter describes the data analysis process used to derive themes in participants' written accounts.

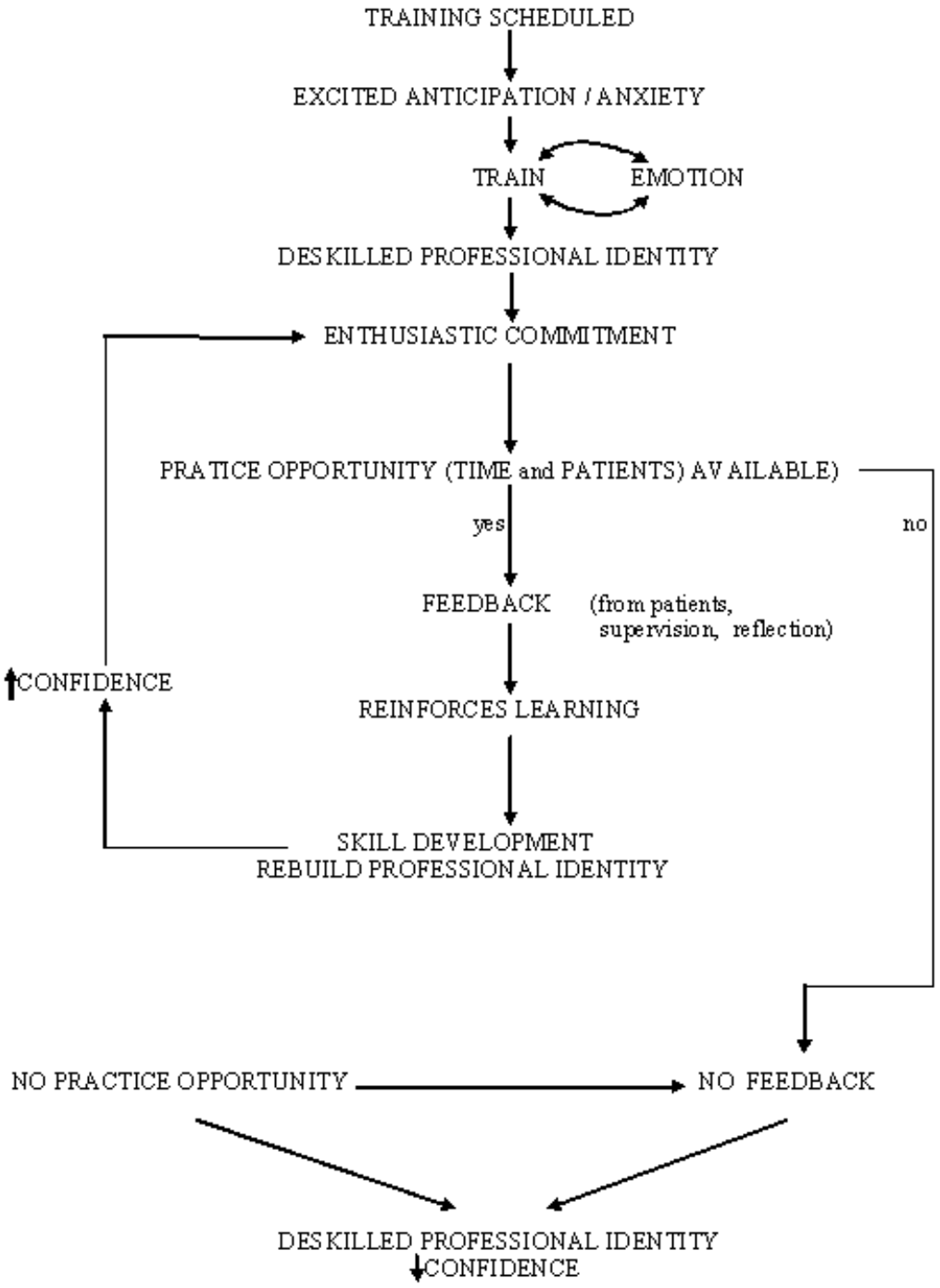
The next part of the report describes the study's findings. In Chapter 4 the findings in relation to how clinicians experience learning MI are discussed in detail. This is represented diagrammatically in Figure P.1 below.

Chapter 5 then discusses the implications for MI training programmes and theory, before the study's strengths and limitations are outlined.

Chapter 6 discusses reflections on the decision to adopt a TA approach and the potential influences of the researcher's multiple roles in relation to MI and the research participants.

The report ends with concluding remarks which summarise the salient findings and how these can inform future training and research, and a brief overview of the impact that the thesis has potentially already had on MI training programmes and associated research.

Figure P.1 Diagrammatic representation of the experiences of leaning MI



Chapter 1 Why explore Motivational Interviewing training experiences?

Contents

This chapter sets the study in context and provides an overview of the rationale behind its conception and design. The study's aims will be outlined and the specific research questions listed. A brief description of the participants and an overview of the methodology will also be provided.

1.1 Background to study

Health psychology studies people's attitudes, behaviour and thinking about health and illness, and aims to promote changes in these in order to prevent illness and help people cope with illness and unpleasant medical treatments when they occur. The breadth of the discipline is far-reaching, and it uses psychological theories and interventions to promote healthier behaviours and reduce those that are damaging. This necessitates understanding health-related cognitions and investigating the processes which can explain, predict and change health and illness behaviour. It also explores and endeavors to improve processes influencing health care delivery and to enhance communications between health care practitioners and patients to improve understanding and treatment adherence.

This work has led to models of health and illness related behaviour and has developed an understanding of psychological concepts that influence health choices and behaviours. Ogden (2007) summarizes these models of health behaviour (e.g. health belief model, theory of reasoned action, theory of planned behaviour, and protection motivation theory) which explore and theorize the influences of such concepts as health related beliefs and attributions, intentions, self-efficacy, health locus of control, social norms, and readiness to change. These models have been criticised and counter defended, nevertheless they have shown that the factors they explore differentially influence health behaviour and health outcomes across populations, and health and illness contexts (Ajzen & Fishbein, 2004, Ogden, 2003). This work has revealed that factors both internal and external to an individual are influential. Importantly there exists both commonality within and variability across illness contexts, as well as individual differences, sometimes idiosyncratic and

irrational, in individuals' beliefs, intentions and their resulting behaviours (Ogden, 2007).

In 2008, the Scottish Government published 'The Matrix', a document summarising which psychological interventions are best supported by scientific evidence. It defines psychological therapies as "a range of interventions, based on psychological concepts and theory, which are designed to help people understand and make changes to their thinking, behaviour and relationships in order to relieve distress and to improve functioning" (NHS Education for Scotland, 2008, p.9). The skills and competencies required to deliver these interventions effectively are acquired through training, and maintained through clinical supervision and practice. Of the modalities of therapy most commonly provided within the NHS in Scotland, Cognitive Behavioural Therapy (CBT) is by the far the most widely researched in terms of its effectiveness. CBT training courses exist at certificate, diploma and post graduate levels, and following supervised practise, practitioners can become accredited through the British Association for Behavioural and Cognitive Psychotherapies (BABCP), the lead organisation for CBT in the UK (NHS Education for Scotland, 2008, p.9).

MI is a psychological consultation style which is "a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p. 25). It is used to enhance a patient's motivation to change their behaviour in order to better manage illness or to promote a healthier lifestyle. This is done by exploring an individual's ambivalence in relation to changing behaviour, and by helping the patient recognize and resolve the discrepancies between their current behaviour and their desired behaviour, (Miller & Rollnick, 2002).

Although MI is not mentioned in 'The Matrix', empirical support has been published for the efficacy of MI in various health care contexts, in relation to numerous illnesses, with numerous health behaviours and across many professional disciplines. Much of this evidence has been consolidated in several systematic reviews (Britt, Hudson, & Blampied, 2004; Burke, Arkowitz, & Menchola, 2003; Burke, Dunn,

Atkins, & Phelps, 2004; Dunn, Deroo, & Rivara, 2001; Hancock, Davidson, Daly, Webber, & Chang, 2005; Hettema, Steele, & Miller, 2005; Knight, McGowan, Dickens, & Bundy, 2006; Martins & McNeil, 2009; Noonan & Moyers, 1997; Rubak, Sandbaek, Lauritzen & Christensen, 2005). However Britt et al (2004) concluded in their review that although MI held promise for promoting health behaviour change, scientific evaluation of the method remained behind MI's clinical innovation, and they highlighted the need for further research to establish MI's efficacy with health problems and its underlying processes and components. While Martins and McNeil (2009) report that later studies are methodologically more sophisticated, they concluded that MI's active ingredients and underlying processes remained unexplained. In addition to further improving the overall study designs, they suggest that future studies should assure adequate power, improve or at least measure attrition, and provide adequate training to those who are performing MI and measure their adherence. Finally, although Miller and Rose (2009) have begun to outline a theory of MI this is still at a rudimentary stage.

In summary, although they report shortcomings in MI efficacy studies, and the above reviews do not always meet guidelines for the reporting of systematic reviews and meta-analyses (Moher, Liberati, Tetzlaff and Altman, 2009; Moher, Cook, Eastwood, Olkin, Rennie and Stroup, 1999; Mulrow, 1987; Liberati, Altman, Tetzlaff, Mulrow, Gøtzsche, Ioannidis, et al, 2009), their findings are nevertheless interpreted as providing evidence for the efficacy of MI and have encouraged its dissemination worldwide, and MI has now been translated into at least 38 languages with more than 1,500 people being trained as MI trainers (Miller & Rollnick, 2009).

Concurrently, recent initiatives, policy-drivers and clinical guidelines in the NHS support the increased use of psychological models and MI in health settings and in primary care (Scottish Executive, 2005a, 2005b, 2007; Scottish Government, 2007a, 2007b; the London School of Economics, 2006). The Scottish Intercollegiate Guidelines Network (SIGN) also recommends the use of MI in addictions, cardiac, angina, stroke and diabetes care, and that staff are suitably trained in this approach.

This growing interest in MI means that its practice and the demand for professional training have become widespread. Alongside this, there exists a demand for evidence based practice and concern surrounding the fidelity and quality by which MI is implemented (Moyers, Martin, Catley, Harris, & Ahluwalia, 2003; Rollnick & Miller, 1995). Rollnick, Miller, and Butler (2008) emphasize that MI comprises complex clinical skills which are difficult to learn and develop with considerable practice over time.

Increasingly, non-psychology trained clinicians are being trained in this therapeutic method. Currently there has been very little research done to explore how such clinicians experience MI training, and how they subsequently consolidate this learning and incorporate it into their clinical practice. Such knowledge would inform future training programmes and facilitate quality training and ultimately patient service and health outcomes. It would also help towards the requirement that clinical practice should be evidence-based. This study is exploratory and extends the research into how multidisciplinary health professionals experience learning MI. In so doing it is hoped that some light can be shed on how best to approach training such individuals.

This research project is timely and informative. Recently there has been an enormous political recognition of the value of psychological care in the management of medical conditions and a drive to increase psychological care in medical settings. The NHS is currently under pressure to change in order to satisfy needs arising from many current demographic shifts. Several reports, strategies and initiatives highlight the need to utilize more psychological approaches to facilitate individuals in health behaviour change and illness management, and for non-psychology trained clinicians to provide these. These reports include:

- ‘Better Health, Better Care: Action Plan’ (Scottish Government, 2007a)
- ‘Coordinated, Integrated and Fit for Purpose’ (Scottish Executive, 2007)
- ‘Living Well with Long Term Conditions in Scotland’ (Scottish Government 2007b)

- ‘Gaun Yersel! Being Human: the self management strategy for long term conditions in Scotland’ (LTCAS, 2008)
- Recommendation of the ‘Layard Report’ (London School of Economics, 2006)
- Recommendations of the ‘Kerr Report’ (Kerr, 2005) and the resulting ‘Delivering for Health’ initiative (Scottish Executive, 2005a)
- ‘Doing Well by People With Depression’ initiative (Scottish Executive, 2005b)
- Towards a Healthier Scotland – A White Paper on Health (Scottish Executive, 1999)
- Our National Health : A plan for action, a plan for change (Scottish Executive, 2000)
- Choosing Health White Paper (DOH, 2004)

Additionally, Scottish Intercollegiate Guidelines Network (SIGN) and National Institute for Health and Clinical Excellence (NICE) guidelines are increasingly recommending psychological approaches to manage mental and physical health and have implications for training in psychological principles for multidisciplinary health professionals. These include:

- SIGN 55 for diabetes (SIGN, 2001)
- SIGN 57 for cardiac rehabilitation (SIGN, 2002)
- SIGN 84 for breast cancer (SIGN, 2005)
- SIGN 96 for stable angina (SIGN, 2007)
- SIGN 108 for stroke (SIGN, 2008)

Theses recommendations and guidelines recognize that changing health behaviours and successful life style and illness management “depends on professionals understanding and embracing a person-centred, empowering approach in which the individual is the leading partner in managing their own life and condition(s).” (LTCAS, 2008, p. 10).

To satisfy growing demand with existing resources, increasingly a stepped care model is being proposed and implemented. As defined by the Scottish Executive's (2005b) 'Doing Well by People with Depression' paper, when using this model "professional care is 'stepped' in intensity, beginning with limited professional input including systematic routine assessment and preventive maintenance through to specialist care" (p. 10). This stepped care approach and current mental health strategies necessitate the wider use of psychological approaches amongst NHS staff, many of whom are not psychological therapists, and thus need to be taught to use psychological models (NHS Education for Scotland, 2008). It is therefore becoming increasingly important to evaluate the teaching of psychological approaches to non-psychologically trained health professionals.

The NHS is currently directing efforts to provide a holistic approach to mental and physical health care and efficient delivery of current provisions. This also requires that non-psychologist health professionals make use of psychologically informed approaches. This project will begin to inform how this can best be done.

In summary, non-psychologically trained health professionals are increasingly being trained in psychological models and are expected to become competent in psychologically informed therapeutic skills and consultation styles. However, very little research explores how health professionals manage this learning process, and how they as individuals and members of regulated professions experience this. This study through exploring health professionals' experiences of learning MI, begins to fill this gap by exploring what individual and common experiences exist, and thus informing future training and research requirements in the area.

1.2 Why a qualitative approach?

Patton emphasizes that before embarking on qualitative research one should ensure that a qualitative approach fits the research question(s). He lists instances that lend themselves to qualitative enquiry:

> questions about people's experiences; inquiry into the meanings people make of their experiences; studying a person in the context of her or his social/interpersonal environment; and research where not enough is known about a phenomenon for standardized instruments to have been developed (or even ready to be developed). Patton (2002, p. 33)

The current study's aims and characteristics lend themselves to all of the above instances, and qualitative enquiry was therefore deemed entirely appropriate. Hence, a qualitative approach was taken using an inductive Thematic Analysis (TA) which Braun and Clarke (2006) describe as being a particularly useful method for investigating under-researched topics, or where participants' views on the topic are unknown. Health professionals who had recently followed MI training programmes were invited to reflect on their learning experiences and to describe this either by completing an open-ended questionnaire or by keeping a reflective diary relating to their learning experiences.

All participants had completed an MI training, and although they have varied backgrounds, they had in common that they were non-psychologists (with the exception of one clinical psychology trainee and one newly qualified clinical psychologist who were included in order to explore how similar or dissimilar their experience were to those of non-psychologists) who had been trained in this psychological model, which, if incorporated into their practice, would require reflection, attitudinal change, and for some, unlearning their existing consultation styles and habits. It can be hypothesized that this is extremely difficult to achieve, that conflict may arise relating to professional identities and boundaries, and that adjustment and consolidation into everyday practice will take considerable time. At this time little is known about what problems arise and how such professionals actually manage this change process.

Thus, this study attempts to grasp how learning MI is experienced by individuals in the context of their professional lives. It does this through a thematic analysis of questionnaire and reflective diary data from 23 multi-disciplinary health professionals.

1.3 The research questions

The research questions were:

> *How do multi-disciplinary clinicians learn and experience the use of Motivational Interviewing (MI) as a consultation method and how can this learning process be facilitated or hindered?*

Chapter 2 MI theory, practice and MI training and dissemination literature

Contents

In order to explain what MI training courses are attempting to achieve, this chapter will describe the MI consultation methods and approach, before the extant literature relating to MI training is discussed. Finally a brief discussion of some of the theories on the adoption and dissemination of new behavioural technologies will be presented.

2.1 MI theory, definitions, strategies and techniques

As already stated, MI is a directive, client-centred approach which facilitates behaviour change through allowing clients to explore and resolve ambivalence. It is directive in that it is more focused and goal-directed than non-directive counselling and the counsellor is intentionally directive in pursuing the resolution of ambivalence.

One of the training courses from which participants of the current study were recruited provided training based upon Behavior change counseling (BCC) which was formerly described as an adaptation of MI. BCC is, in essence, a distillation and refinement of MI methods adapted for brief consultations in healthcare settings. Although this method has little research evidence to suggest its efficacy it is nevertheless an excellent introduction and foundation for MI and health behaviour change consulting more generally (Lane et al, 2005; Rollnick, Mason & Butler, 1999; Rollnick et al, 2002). More recently a new text has been published in which it is claimed that references to MI had previously been avoided in relation to BCC for fear of “diluting MI beyond recognition” (Rollnick, Miller & Butler, 2008, p. viii). This new publication appears to describe BCC but refers to it as Motivational Interviewing in health care. This somewhat confusing situation suggests that differentiating MI and BCC was somewhat meaningless, and this new publication can be seen as an attempt to redress this. Unless it is necessary to differentiate between the two methods, for the purpose of this report both MI and BCC will be referred to as ‘MI’.

Furthermore, Miller and Rollnick (2009) include their own text introducing BCC, as one of several adaptations of MI which introduce new terminology for closely related practices (Botelho, 2004; Miller, Zweben, DiClemente, & Rychtarik, 1992; Rollnick, Mason and Butler, 1999; Tober and Raistrick, 2007), and which may lead to "public and professional confusion regarding a clinical method" (p. 137). These adaptations and training literature pertaining to them will not be discussed here.

Miller and Rollnick (2002) describe the *spirit* of the MI approach which they see as fundamentally underpinning the method and they emphasize this over particular techniques of MI. This spirit encourages a way of being with people which allows the therapist to understand the client's experience. This understanding is expressed non-judgmentally in the hope that the client too can come to understand the nature of their experience, and the consequences which their decision making and behaviours have on their health. In promoting the spirit of the approach, firstly the therapeutic relationship is *collaborative*, forming an equal partnership where the client is seen as the expert rather than the clinician as is the case in more traditional approaches. Secondly the resources and motivation for change are assumed to reside within the client and the therapist's aim is to *evoke* or *elicit* these from the client. Thirdly client *autonomy* and *freedom of choice* are respected and emphasized throughout the encounter.

Unlike more traditional consultation approaches, direct persuasion, advice giving, argumentation and coercion are not seen as conducive to client change, and are therefore discouraged. Health professionals who have been trained in taking a more authoritarian, expert approach therefore may have to change their attitudes and beliefs and to unlearn old habits. This can be a challenging aspect of learning MI for experienced clinicians.

Practicing MI involves many strategies and techniques. Foremost amongst the skills and behaviours that clinicians will have to learn are: reflective listening; expressing acceptance and affirmation; affirming the clients autonomy and self-direction; eliciting and selectively reinforcing the client's utterances which may help resolve their ambivalence; monitoring the client's degree of readiness; recognizing and

managing client resistance; eliciting and selectively reinforcing the client's utterances which indicate commitment to change; and negotiating and facilitating the development of change plans.

Miller and Rollnick (2002) conceptualize MI as occurring in two phases. The first phase involves building intrinsic motivation for change. Here traditional Rogerian counseling skills of open questioning and empathic listening will be used to explore the client's *readiness to change* and *ambivalence*. Readiness to change is conceptualized on the two dimensions of *importance* and *confidence*, and strategies are utilized to explore and develop these. In phase 2 the emphasis shifts to strengthening commitment and to constructing a change plan. Phase 1 skills and strategies are used in phase 2 but in the latter the emphasis is on developing and strengthening commitment to the change plan.

2.2 What is known about MI training?

This section will discuss the salient points that emerge from the extant literature relating to MI training.

As already stated, MI can be utilized by many health professions and across a broad range of health care contexts. There have been several recent developments in MI training (Adams & Madson, 2006). Firstly, the Motivational Interviewing Network of Trainers (MINT) was set up with the aim to promote quality training in MI. Secondly, the training process and the transfer of MI skills into practice have been examined empirically. Thirdly, several observational measures have been developed to facilitate monitoring, feedback, and research on MI competence and adherence (Barsky & Coleman, 2001; Lane et al, 2005; Madson, Campbell, Barrett, Brondino, & Melchert, 2005; Miller and Mount, 2001; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005; Rosengren, Baer, Hartzler, Dunn, and Wells, 2005). However Miller and Moyers (2006) state, "there has been very little progress toward skill-specific measures", and while these instruments are promising, they still require further psychometric testing before they can be rigorously utilized in assessing MI

competence (Allsop, 2007; Madson & Campbell, 2006; Turner & Wallace, 2009; Wallace & Turner, 2009). Finally, to evaluate and synthesize the burgeoning research into MI Training, Madson, Loignon, and Lane (2009) conducted a systematic review of current MI training practices and outcomes. This review and salient MI research literature relevant to the current study will now be discussed.

Research suggests that participation in MI training workshops alone will not result in MI competence (Miller & Mount, 2001; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). Miller and Mount state that reading about MI, viewing videotapes or attending clinical workshops will not result in clinicians becoming proficient MI practitioners. They add that a one-stop workshop is not sufficient to make any difference to client response, and that training must help clinicians learn MI from their clients. Furthermore Miller et al (2004) report that a 2-day MI training workshop without further coaching and supervision yielded modest gains which returned to baseline after 4 months, and that no significant improvement is made through self study using a therapist manual and training videos. Miller et al however found that proficiency in MI was achieved when trainees were provided either systematic feedback on their performance, personal skill coaching or both. Miller et al additionally found that patient responses improved only when seen by trainees who received both feedback and coaching. In line with these findings Rubel, Sobell, and Miller (2000) suggest that therapist practice should be monitored and wherever possible supervised following MI training.

These findings are backed up by Walters, Matson, Baer, and Ziedonis (2005) who conducted a systematic review of the effectiveness of workshop training for psychosocial treatments in addictions. They highlighted that while the workshop format improves trainees' knowledge, attitudes, and confidence, and although some skill acquisition is evident immediately following workshops, it is rarely maintained over time.

An additional concern exists whereby although workshop participants self-report that they are reasonably proficient, this seldom correlates with actual increases in proficiency (Miller & Mount, 2001). Additionally Miller and Mount warn that a false

perception that they are proficient inoculates clinicians from participating in further MI training. Increased confidence and self-efficacy, and the intention to practice MI are desirable outcomes of MI training programmes (Madson et al, 2009), but the foregoing findings and warnings concerning misconceived beliefs in relation to acquired MI skill after training, highlights the need to balance trainees' positive perceptions with objective and constructive feedback on clinical performance.

These findings are not surprising and many of the MI training studies could be accused of stating the obvious given that it is widely recognized that clinical supervision is necessary to deliver any psychological therapy, and that this supervision is essential both during training and thereafter to ensure the ongoing safety and quality of consequent practice. (NHS Education for Scotland, 2008). This illustrates a critique that can be levelled at much of the MI training literature which reports such findings as if they are novel and even non-hypothesized. Thus these studies rarely appear to have sound theoretical underpinnings. Michie and Abraham (2004) writing from a health psychology perspective in relation to health behaviour change interventions, warn that if behaviour change interventions are not based upon theory, then their application may be slow with ‘‘'wheels' being re-invented rather than re-applied" (p. 30). They argue that atheoretical interventions do not build on existing knowledge and that intervention design may be derived from implicit theories that may omit psychological processes central to behaviour change and therefore fail to achieve optimum outcomes. MI training programmes are in effect behaviour change interventions aimed at changing the behaviour of health professionals, and as such run the same risks if they are not theoretically founded.

The MI training research can be criticized as theory is rarely mentioned, and one may question whether the science behind MI training might have advanced more rapidly had this not been the case. For instance the findings described above make sense since the theories of adult learning emphasize the need for practice and feedback to master a complex skill. Had these theories been utilized in the design, execution, and reporting of MI training research then perhaps more practical and applied knowledge may have resulted in relation to what facilitates the development of MI competency

and how this can best be applied and utilized. Theories of adult learning which are relevant and informative to MI training and skill building include: experiential learning cycle (Kolb, 1984); Ripples Theory (Race, 2005); constructivism (Biggs, 2003); social constructivist theories (Vygotsky, 1978); and Social Learning Theory (Bandura, 1977, 1986).

These models highlight that learning will be most effective when learners participate actively, and social interaction, observation and modelling are encouraged. Taking time to reflect after trying a new skill and recording observations are examples of how this can be done in the workplace. In this way these theories are implicit in learning through reflective practice which is discussed next.

Kolb's (1984) cycle of adult learning, emphasizes the need for active learning and reflection to assimilate learning with prior knowledge and experience. Boud, Keogh, and Walker. (1985) suggest that time should be built into training to allow for reflection which can be achieved through discussion, debriefing with others or through keeping reflective diaries. Trainers can facilitate this by helping learners to objectively articulate experience, to pay attention to their feelings and then to assimilate their learning within their work context. Schön (1983) argues that theoretical knowledge, such as that imparted on training courses, is not always readily applied to the non-textbook problems encountered in real life, such as a patients' predicaments. His recommendation that reflective practice is a key skill within adult learning is increasingly recognized as a way to bridge the theory into practice gap.

These learning models are not mutually exclusive and they complement each other. They highlight that learning will be most effective when 'theory to practice' links are built into the training. Active participation and practice should be incorporated into training programmes, and appropriate feedback and reflection opportunities should also be included or encouraged soon after training. These theories are outlined in more detail in appendix 1.

Next, further relevant findings from MI training research will be discussed and how these relate to adult learning theories will be highlighted.

The evidence in MI training research suggests then that clinicians are more likely to become competent in MI when they are provided with consistent, structured local support, monitoring and supervision (Carroll et al 2006; Miller et al 2004; Söderlund, Nilsen, and Kristensson, 2008). This is entirely in line with Race's (2005) Ripples Theory which proposes that feedback is linked to *learning by doing* and is most facilitative if received either as part of or temporally close to the practice. Race argues that feedback can arise from many sources and at many opportunities, and can be received as constructive critical feedback from mentors, teachers, trainers, and others, but also intrinsically through one's own and others' reactions when doing something.

Söderlund et al (2008), researching nurses, highlight barriers to adopting the MI approach. They claim that it is especially difficult when clinicians have been trained in taking an authoritarian, expert, information giving approach as this contrasts with the MI approach which sees the patient as the expert in their own self-management. The nurses saw as a hindrance to successfully practicing MI, patients who were passive and unwilling to assume responsibility for their health and behaviour. The nurses also reported that using a combination of training workshops and gradual implementation and honing of skills in real-world clinical settings over time provided a link between theory and practice which they regarded as essential in learning MI. Söderlund and colleagues suggest that learning MI requires modification to attitudes relating to clinicians' roles and relationships with clients. They advise therefore that MI training should focus on attitude change as well as skill training. These findings suggest that training will be most successful when it is based on a practical model which integrates with the existing skills and existing knowledge and understanding of the staff. This dovetails well with the constructivist and experiential models of adult learning.

Social constructivist theories (Vygotsky, 1978) emphasize the role of social interaction in learning. Vygotsky's concept of the 'zone of proximal development'

(ZPD) emphasizes how children learn through being helped by another whose skill in what is being learned is greater than their own. Thus the ZPD relates to what one can do with the help of another, and is a stage towards doing something on one's own. The help and support provided can take many forms and is often referred to as 'scaffolding' which is reduced and eventually removed as the individual becomes more proficient. The constructs of ZPD and scaffolding have been expanded to adult learning (Tinsley and Lebak, 2009). Rollnick et al (2008) state that access to a clinician who is proficient in MI will facilitate a trainee's learning. Viewing a more experienced clinician, a coach, or a supervisor as 'more skilled others' who can facilitate or scaffold the trainees' learning, highlights the relevance of Vygotskian theory and raises pedagogical considerations for MI training endeavours. In particular every trainee will bring something different to the training context, therefore their ZPD may vary, raising concerns relating to what scaffolding is appropriate and facilitative for which trainees during their learning.

Rollnick et al (2008) state that practice without feedback can be unhelpful and can produce bad habits. Feedback can be received in the form of formative feedback from trainers, mentors, supervisors and peers. Additionally, Rollnick et al describe how clients provide instant and reliable feedback during consultations, and how their reactions provide immediate opportunities for skill development. For this reason Rollnick and colleagues suggest that trainees should learn how to learn from their clients. Through practicing MI with clients they claim that a clinician begins to notice what questions open up consultations about behaviour change, and starts to identify the range of change talk in clients' utterances. This is in line with Race's theory that reflection, feedback and digestion are facilitative processes that occur concurrently while practicing.

Miller and Rollnick (2002) and Rollnick et al (2008) describe a revised MI training approach that emphasizes the underpinning assumptions and spirit of MI, and a focus on learning from clients rather than an aim to build skill and competence in a workshop. When training comprised how to learn from clients Amrhein, Miller, Yahne, Palmer, and Fulcher (2003) found that MI skill acquisition improved and

proficiency was maintained or improved at one year follow up. This "learning-how-to-learn" approach echoes Race's (2005) theory of adult learning. Race recommends that educators should help learners understand how learning happens, and suggests that "perhaps the most important outcome of any element of learning is that of becoming a better learner bit by bit" (p. 14).

When a trainee can recognize "change talk" and "commitment talk", the client's verbalizations also shape the therapist's behaviour and provide immediate feedback on how well their MI skills and performance are developing (Miller & Moyers, 2006; Amrhein et al, 2003). This concurs with Race's suggestions about the types of feedback that facilitates learning complex skills and may explain the significance of learning from one's clients and the importance of the trainee understanding this process.

This model of training along with the recent Eight Stages in learning MI Theory (Miller and Moyers, 2006) which is discussed next, have implications for what is appropriate in evaluating training outcomes.

From their own observations of individuals learning MI, Miller and Moyers (2006) hypothesize an eight stage learning process that those learning MI traverse before they can reach MI competency. Although this proposed trajectory requires to be tested empirically, they purport that each stage is a prerequisite for the next and suggest that training programmes should be structured to the needs and learning stages of participants. The first five stages comprise MI Phase 1 skills described earlier, and the remaining three stages relate more to MI Phase 2 skills (see Table 2.1).

Table 2.1 Overview of Eight Stages in Learning Motivational Interviewing

MI Phase 1
Stage 1 overall spirit of MI – let go of righting, collaboration, curiosity etc
Stage 2 OARS client centred counselling skills
Stage 3 recognising change talk and resistance
Stage 4 eliciting and strengthening change talk

Stage 5 rolling with resistance
MI Phase 2
Stage 6 negotiating a change plan
Stage 7 consolidating commitment – eliciting commitment talk
Stage 8 transition and blending with other approaches

The eight stages are as follows:

1) *Utilizing the spirit of MI* requires trainees come to respect the client's autonomy and expertise in their own health and to forego any authoritarian or expert stance.

2) *Proficiency in client centred counselling skills* which allow the client to explore their experience and ambivalence in a supportive, non-judgmental, and facilitative therapeutic relationship. This requires using active and empathic listening skills which involves using the techniques of open questioning, affirming, reflecting and summarizing which are often referred to using the acronym OARS techniques.

3) *Recognizing change talk and resistance* which requires the trainee to be able to recognize the aspect of clients' speech that signify change in the desired direction and to recognize counter change arguments otherwise referred to as *sustain talk* or *client resistance*. Client behaviour change has been shown to be more likely when the client expresses *commitment* to change and this is usually preceded by expression of *desire*, *ability*, *reasons*, and *need* to change (Amrhein et al, 2003). Behaviour change has also been shown to be inversely related to client resistance (Miller & Moyers, 2006). The trainee therefore has to be able to recognize clients' change talk and resistance if desired outcomes are to be achieved.

4) *Eliciting and strengthening change talk* is related to Stage 3 but here being able to recognize change talk, the trainee can then begin to learn how to actively utilize techniques and strategies that evoke and reinforce change talk.

5) *Rolling with resistance* is the skill which when achieved will enable the trainee to avoid argumentation and confrontation with a client. Resistance is seen as natural and inevitable in any change process and the ability to roll with it rather than opposing it is necessary if behaviour change in a positive direction is to be facilitated.

6) *Negotiating change plans* requires the ability to judge from clients' change talk, their readiness to commit and negotiate a change plan. This shift from discussing *why* to change to *how* to change signifies a transition from Phase 1 to Phase 2 and the clinician's intentions and strategies to evoke this should be timed appropriately in order to discourage resistance. Proficiency in this stage therefore requires skilful timing and negotiation.

7) *Consolidating commitment* requires the skill to elicit and strengthen client verbalizations that indicate commitment to change. Amrhein et al (2003) showed that change was unlikely to occur in the absence of client expressed commitment talk. This stage therefore requires clinical skilfulness in listening for and eliciting commitment talk.

8) *Transition and blending* is the skill to combine and blend the MI style with that of other therapeutic interventions and models and to transition flexibly between MI and other approaches. MI has been demonstrated to have synergistic effects when combined with other models and this skill to switch to another style is necessary for many clients at different stages in their change process.

Miller and Moyers (2006) stage theory provides a plausible structure for assessing MI training and clinicians' skill development, but their article is also somewhat contradictory. On the one hand they claim that each of the above skills is a prerequisite to attaining the next. Elsewhere in the paper they describe for some stages why this might not be the case. Miller and Moyers acknowledge that their theory requires empirical examination but it forms nevertheless a good basis to begin exploring the processes involved in learning MI.

The aims of the systematic review conducted by Madson et al (2009) were to provide a synthesis of current MI training practices and outcomes, in order to facilitate researchers, educators, and clinical supervisors in developing and evaluating MI training. While the review is informative for the current study, its rigor is questionable and the report contravenes several of the current guidelines for reporting systemic reviews as described by the PRISMA statement (Moher et al, 2009) and earlier guidelines (Moher et al, 1999; Mulrow, 1987). Since not all journals require that their reports conform to the above guidelines some of the problems with the review may be due to publication restrictions.

What follows is an outline of the more obvious and problematic issues identified with this systematic review. Crucially Madson et al (2009) do not describe any critical assessment of the studies included in their review. Liberati et al (2009), state in their explanations and elaboration of the PRISMA statement, that it is important for reports to describe how included studies are assessed for 'risk of bias', and that when this is not the case a rationale for not doing so should be provided. Madson et al's report describes neither. They have not included a flow diagram to summarize the study selection processes, and the reasons for excluding studies are not described for all excluded studies. Further the review does not report the date upon which databases were searched, therefore it is not possible to assess the comprehensiveness and completeness of the search, nor to replicate it. Snowballing from reference lists is not described, and grey literature does not appear to have been included in the search leaving the review open to publication bias. Madson et al have not described the study designs (e.g. whether they are RCTs or observational studies) of included studies therefore it is not possible to assess how robust and reliable their findings may be. They have also included misleading information. For example they describe in their results including 27 studies, but on a further two occasions mention 28 included studies. They also describe excluding a study only to refer to this study in their discussion in a way that suggests it contributes to their findings. Finally their findings are often described in misleading ways. For instance the report states that "most trainings demonstrated positive outcomes relating to the development of MI knowledge, attitudes, basic skills, self efficacy, interest in MI, and willingness to use

MI" (p.105). However closer inspection of their results table reveals that only 10 (37%) of the studies reviewed included any of these outcome measures.

While the reporting of this systematic review may not be as rigorous as it could be, for the purpose of the current project it is informative in that it nevertheless summarizes what research into MI training has thus far accomplished. It also summarizes how the included MI training courses were conducted and therefore facilitates assessment of the representativeness of the training programmes from which participants were recruited for the current study.

Twenty seven studies were included in the review. Health contexts researched included medicine, general health care (e.g. nutrition and exercise), substance abuse and general mental health. The studies provided MI training to a wide range of health professions including physicians, nurses, dieticians, social workers, counsellors, and psychologists.

The majority used a workshop format, and the training program durations varied from 8 hours to 16 hours with one study involving 24 hours of training. Only a few training courses included follow-up and ongoing contact with the trainer as a coach or supervisor. The content of the majority of courses included didactic instruction and experiential exercises including role plays, group discussion, modelling activities, such as observing video or live demonstrations, and the use of reading or outside content homework. Some discussed trainee feedback which was usually provided by the trainer or by peers.

In relation to outcomes, small numbers of studies reported increased participant confidence in using MI (n = 4), MI knowledge (n = 6), interest in learning more about MI (n = 3), intention to utilize MI (n = 6), and actual integration into participants' practice (n = 2). In seven studies, participants found value in the training and in two studies the participants found role plays to be particularly helpful.

In relation to the eight stages theory, Madson et al (2009) claim to have assessed which of the 8 stages of learning MI have been addressed in the courses. Caution is

warranted in relation to this as their assessment criteria are rather vague and somewhat subjective. For instance if studies described addressing "principles of MI" (p. 104) then stages 1, 2, 3 and 5 were deemed to have been addressed. This does not constitute a rigorous method of performing this assessment. Nevertheless, they report that all studies reviewed were assessed as addressing Stage 2, and most as addressing Stages 1, 3 and 5. All the courses were assessed as focusing on Phase 1 MI skills, and unless journal space limitations led to their omission, none addressed stages relating to Phase 2 aspects of MI.

Madson and colleagues describe several limitations in the studies they reviewed. Firstly most studies relied on a workshop format for their training and only a few provided supervision (n = 4) or ongoing coaching (n=1). Given the evidence cited above this reliance on the workshop format is problematic as skills learned this way are not usually maintained in the long term. Secondly, the aims and contents of the courses were not always well described. This renders scientific replication difficult and from a practical perspective it results in low external validity which limits the implementation of potentially effective training methods (Davidson et al, 2003; Des Jarlais, Lyles, & Crepaz, 2004; Downs & Black, 1998; Glasgow, Bull, Gillette, Klesges, & Dzewaltowski,, 2002). Thirdly, the studies reviewed comprised primarily pre-post training designs. Again, given the evidence that skill is consolidated over time with supervision and coaching, and the theory that learning may occur in eight stages, the need to assess skills over time is stressed. A final shortcoming found in the review was that few studies examined client outcomes. The authors suggest that to empirically advance MI training future studies should examine the impact of MI training on clients.

Additionally had Madson et al (2009) critically assessed the included studies, further limitations may have been revealed. For instance in addition to the lack of theory already discussed, observational studies are often relied upon, participant flowcharts are often omitted, and objective skill outcomes are often appraised using the still to be fully validated MI adherence measures discussed above (Allsop, 2007; Madson &

Campbell, 2006; Turner & Wallace, 2009; Wallace & Turner, 2009) or through non-validated, one-off measures developed for individual studies.

In summary, it is apparent from the current review of the MI training literature that, like MI efficacy literature (Allsop, 2007), much of the published training research has fundamental problems or oversights which hinder scientific progress and practical understandings. Firstly, adoption of MI and training in MI has progressed with a limited theoretical base. This makes it difficult to ascertain, and consequently understand, the crucial and effective components and processes of MI and training. Secondly, with the delayed progress in developing reliable and practical instruments and assessment methods, training and supervision outcomes are difficult to assess. Thirdly the MI training research reports often do not comply with reporting guidelines for behavioral interventions, and many were found to have provided insufficient detail to determine training context and content and allow external validity and relevance to other settings to be assessed.

This latter issue is not necessarily the fault of the authors of MI training research, as training studies have additional dimensions that are not yet accounted for in existing guidelines for reporting behavioural interventions, including TREND (Des Jarlais *et al*, 2004) and CONSORT (Davidson *et al*, 2003). Reporting of criteria relating to external validity are emphasized by these and additional authors (Downs & Black, 1998; Glasgow *et al*, 2002; Khan & Kleijnen, 2001; and Petticrew & Roberts, 2006). Research relating to the training of health professionals and dissemination of such research into practice has additional external validity implications which are not considered in existing guidelines. For instance important issues which potential consumers must assess before utilizing an intervention or a particular outcome measure include: factors that influence training efficacy or effectiveness, adoption, implementation and maintenance; context; rater demographics and rater training; trainer demographics; training context, content and duration; and trainee demographics, professions and therapeutic experience. This data is often either omitted or loosely described in MI training papers and should be considered in

future reporting guidelines for training interventions and studies if consumer decision making is to be facilitated.

Madson et al (2009) suggest that to fully understand how MI is learned, future studies should explore the processes involved in developing skill within both phases of MI. Given that fully validated objective methods of assessing MI competence have not yet been developed, determining whether a trainee has reached MI competency is still complex and problematic. It is nevertheless feasible and informative to investigate how clinicians experience the learning process no matter their competency level or at which stage in their learning they are at. It is therefore timely and useful to explore what facilitates and hinders learning MI and how this learning occurs. Söderlund et al (2008) have begun this endeavor and they state that qualitative methods are the best way to do this. Madson et al also recommend that future MI training research should explore training outcome constructs such as trainees' feelings of confidence and self-efficacy, intention to use MI, their attitudes towards MI, and their knowledge of MI. The current study begins to examine these. Additionally it is hoped that by recruiting participants whose training workshops took place some time in the past, and by describing their training in detail that some of the shortcomings in the extant MI training literature discussed above will be avoided or overcome.

2.3 Dissemination of new practices

MI training is not, as with any behavioural intervention, isolated to individual learners and their outcomes but also to wider services and clinical communities and settings. What has been documented about how behavioural interventions may be adopted into wider clinical setting and communities will therefore now be summarized.

Training outcomes should be considered in the context of the wider processes of technology transfer into routine practice and maintenance of such practice. Walters et al (2005) examined in their systematic review the effectiveness of workshops as

training methods in relation to the dissemination of treatment approaches into wider practice in substance abuse settings. They too concluded that workshops alone were insufficient to bring about enduring therapeutic skill.

Additionally Miller, Sorensen, Selzer, and Brigham, (2006) reviewed wider processes and methods for disseminating effective treatment methods into practice in substance abuse settings. They differentiate between *dissemination* processes which describe "methods for strengthening practice competencies" (p. 26), and *diffusion* processes which describe how "innovations are normally communicated to and adopted my practitioners" (p. 26). They summarized the dissemination literature they reviewed thus: "to learn any new behavioral skill, people need not only informational training but also (1) clear and accurate feedback regarding their performance and (2) guidance from a supervisor/coach who has greater expertise and proficiency in the skill" (p. 35).

Both these reviews' findings are relevant to the current study as the workshops from which participants were recruited can be looked upon as methods of the communication processes of diffusion as described above, but not necessarily sufficient as methods of dissemination and adoption of MI.

Simpson (2002) theorizes four steps involved in the process of technology transfer: *Exposure* to new ideas often occurs through lecture, self-study, workshops, or expert consultation; *adoption* represents an intention to try something new, which may be a formal decision made by an organization or at a more personal level by an individual; *implementation* is a trial period where the new innovation is used and tested for its feasibility and potential; and, finally, in *practice*, providers assimilate an innovation into regular use and maintain this. Walters et al (2005) suggest that workshop training courses are perhaps best considered as fulfilling the exposure step introducing new information, and that it should be acknowledged that other experiences and processes may be needed to move through Simpson's remaining three steps and promote exploratory use and routine practice.

The MI training literature and the dissemination and diffusion literature appear to reach a consensus then that workshops alone are insufficient to bring about adoption of MI. The findings can be integrated and summarized well by considering what Miller et al (2006) describe as three elemental things which appear to facilitate learning any behavioural skill such as MI. Firstly fundamental preparatory knowledge has to be acquired. This can be achieved through reading, verbal instruction, or observing competent practice by others. Secondly practice with feedback is necessary, and without feedback about how well one is doing, repeated attempts are of little value and can quickly cultivate bad habits. Finally, coaching or supervision is needed to reinforce adherent practice and provide tips for skill improvement.

It is evident from the foregoing review that training workshops alone do not result in enduring skill development. Nevertheless they can be seen as a method of exposure to new information (Walters et al, 2005) and despite their limitations, due to economical constraints and scarcity of resources, workshops without follow-up and supervision still remain common practice. In should be noted that while both the training programmes that the participants of the current study attended did offer follow-up supervision, not all participants utilized this and some of those who did may not have received this at the time of their participation. While the MI competence of the participants can not therefore be assumed their experience of the training programmes and learning process is nevertheless informative.

2.4 Why this research is relevant now?

All of the above research examined skill acquisition and with the exception of Söderlund et al (2008) none explored the actual experiences of health professional learning MI. This together with the sheer amount of research and training that is occurring makes a qualitative study of such experience timely.

Söderlund et al (2008) state that the existing MI training research focuses on evaluating outcomes in terms of measuring MI competence before and after training.

They claim that this approach does not provide an explanation for ‘why’ or ‘how’ the results were achieved. They state additionally that they found no studies which investigate the process of learning MI or the critical factors that facilitate or hinder achieving MI competence. Söderlund et al’s study exploring the training and counselling experiences of nurses, aimed to identify key elements in the process of learning and applying MI. Their study begins to remedy the paucity of research on the process of learning MI. It is hoped that the current study will further address this deficiency and fill this knowledge gap further by elaborating the understanding of the process that clinicians experience when they learn MI.

Finally, Lamb, Greenlick, and McCarty (1998) recommend increasing communication between the research community and clinicians to improve the adoption of effective treatments in substance abuse settings. This is likely to be the case in other settings and with this study it is hoped to begin to give clinicians a voice in relation to how they experience learning MI and what facilitates or hinders the learning process.

Chapter 3 Methods

Contents

> "*There is no longer a call for each researcher to discover and defend [qualitative methods] anew. Instead of having to describe and defend qualitative approaches, as we once felt obligated to do, it is often difficult to say anything new or startling about them*"
>
> Wolcott (1990, p. 26)

Heeding Walcott, the following is brief and further justifies the suitability of qualitative enquiry and TA for the current study.

Although the quantitative studies discussed earlier begin to tell us *what* works in relation to MI training, they do not tell us *how* or *why* it works and this knowledge is needed in order to replicate and improve clinical training programmes. To gain further insight, *process* needs to be studied. Patton (2002) states that qualitative enquiry is particularly suitable for studying process. He claims that process is dynamic and fluid and cannot be captured using quantitative measures at one point in time, that detailed descriptions of individuals' perceptions and how people engage with each other are needed, and that individual experience needs to be captured using individuals' own words. All of these considerations can be satisfied using qualitative enquiry.

Braun and Clarke (2006) describe TA as a flexible method which can be utilized with a variety of theoretical and epistemological approaches for identifying patterns or themes within data. It is claimed by some (Boyatzis, 1998; Ryan & Bernard, 2000) that TA is merely a process that is carried out within other qualitative analytic traditions such as grounded theory (GT) and interpretative phenomenological analysis (IPA). Braun and Clarke however argue that TA should be considered a method in its own right and claim that it is undervalued and underrepresented as it is not often named as such in publications. Both GT and IPA, methods which also seek patterns in data sets, were contemplated, and although much of their underlying theory and methods were considered applicable there were was also elements that were not, and TA was deemed the most appropriate approach for the study.

GT originates in sociology and its primary aim was to generate theory about phenomena that is grounded in the data and for this reason GT would normally employ theoretical sampling when recruiting participants. The current study was more exploratory and was not aiming to construct a theory about learning MI. Additionally since the theory relating to this is sparse, theoretical sampling would have been limited. While GT is often used in ways that are more akin to TA than a full-scale grounded theory (Braun & Clarke, 2006), it was nevertheless considered that an explicitly labeled and acknowledged thematic analysis was more appropriate.

IPA is one of several closely related approaches described as phenomenological psychology, whose primary concern is the subjective experiences of individuals. IPA recognizes that it is not possible to access an individual's lifeworld directly because there is no transparent and unmediated window into it. IPA's focus on personal lived experiences makes it particularly suited to topics of a highly personal and often sensitive nature, for example, experiences of personal ill health and major life transitions. Learning MI may have personal elements, however it is unlikely to be as emotive, sensitive and deeply meaningful (i.e. phenomenological) as the topics that IPA is more suited to study. Though not exclusively, IPA data is usually collected using various interviewing techniques and it was also expected that the written data collection methods used in the current study might produce data with less phenomenological depth than is required for an IPA study. IPA is essentially a higher order TA suited to studies with more depth of experience than learning MI might involve, and hence was considered not appropriate for the current study.

Further reflections and elaboration on the choice to utilize TA and its contrast with IPA are discussed Chapter 6.

3.1 Epistemological and theoretical underpinnings

Both GT and IPA are theoretically bounded (Braun and Clarke, 2006) and perhaps it is TA's theoretical flexibility that has led to it being undervalued as a method. Braun and Clarke (2006) suggests that for TA to become better recognized as a valuable

method in its own right, researchers who utilize it should make their theoretical and epistemological assumptions explicit. In exploring experiential aspects of learning MI, and, with the researcher's background in practicing, teaching and learning MI (outlined below), the current study was underpinned by interpretative and contextualist epistemologies which can frame a rigorous and transparently reported TA (Braun and Clarke, 2006).

Experiential, interpretative and contextualist approaches take a relativist stance and explore how things appear to us in experience and how individuals describe their perceptions of objects and events, while taking into consideration the interpretive nature of the research process and the relativity of experience as determined by setting and time. This contrasts with other epistemological stances which attempt to produce objective descriptions of an object or event, or to investigate an object or event in terms of pre-existing conceptual and scientific criteria. Current hermeneutics purport that people, including researchers, are interpreting and sense-making individuals. The research process can thus be seen as a dynamic process with the researcher taking an active role in that process (Smith & Eatough, 2006). Larkin, Watts and Clifton (2006) warn that simply collecting and representing participants' voices oversimplifies the remit of qualitative psychology. They claim that access to 'experience' is always partial and intricate, and is always co-constructed by the participant and researcher. A key aim then is to position findings in relation to wider social, cultural, and theoretical contexts. It is in consideration of these issues that the experiential, interpretive and contextual stance of the current study is manifest.

Madill, Jordan, and Shirley (2000) using the terms '*contextualism*' and '*contextual constructionism'* synonymously state that, contextualism posits that all knowledge is local, provisional, and situation dependent. Therefore a tenet of contextualism is that findings will vary according to the setting in which research is conducted. These contextualist epistemological and theoretical underpinnings are congruent with the current study and are used as a basis with which to explore experiences of learning MI in context.

The contextual nature of the current study is emphasized in relation to:

- the researcher's own relationships and experience with the research subject and participants, which can be viewed as facilitating the researcher in taking an 'insider's perspective';
- the existing knowledge and previous clinical experiences of the participants;
- the individuality and locality of the training programmes and the participants' work environments; and
- in relation to any resulting interpretations.

A commitment to an idiographic approach examining individual experience can reveal common as well as idiosyncratic themes across groups of individuals (Smith, Flowers, and Larkin, 2009). Smith and Eatough (2006) refer to this as an idiographic-nomothetic approach, and they argue that looking closely at individuals will produce knowledge relating to universal laws and structures. In the current study, the ability to consider both these units of analysis would be valuable in investigating how multi-disciplinary health professionals experience learning a consultation style which is firmly rooted in a cognitive behavioural therapeutic style of consultation.

How the world appears to the individual, is the focus in the analysis that follows which privileges the participants' own accounts of their experiences. Using an inductive interpretative TA analysis, theoretical relationships and implication are not hypothesized in advance; rather the extant literature and any theoretical associations and implications are examined during the later stages after the themes contained within the data have been identified.

In consideration of the above, and in order to enable readers to appraise the findings and to assess its applicability to their own contexts and interests, the study will be contextualized next.

3.2 Contextualising the study

> "To demonstrate excellence, studies conducted from within a contextual constructionist epistemology would be expected to show the relationship between accounts and the contexts within which they have been produced. That is, accounts need to be demonstrably grounded in the (e.g. situational, personal, cultural, social, etc.) conditions within which they were produced. This applies to both participants' accounts (e.g. of their experiences, of their thoughts and feelings) and researchers' accounts (i.e. their analyses and interpretations of data). Thus, an important criterion for evaluation within this context is *reflexivity*"
>
> (Willig, 2001, p. 146).

As explained above, this study is firmly underpinned by experiential, interpretative and contextualist epistemologies. Accordingly, following Willig (2001) the purpose of this section is to contextualize the study. First it offers a reflective summary of the research's background and foreknowledge which will have inevitably influenced the method and the findings. Secondly it will describe the study participants' background and experience, and, the context and format of the MI training courses from which they were recruited.

The researcher's background and epistemological position

> "researchers cannot free themselves of their theoretical and epistemological commitments, and data are not coded in an epistemological vacuum."
>
> (Braun and Clarke, 2006, p. 84)

The researcher's background and position is described here in the hope of increasing transparency, allowing the reader to assess the study and its findings while reading what follows, rather than as is often the case, forming an impression and perhaps conclusions which then have to be adjusted in light of reflexivity that is more usually

provided nearer the end of the report. Since this section explores my own experiences prior to and during the research it makes sense for it be written in the first person. In order to allow readers to form their own conclusions on the relevance, validity and utility of the project and its findings, this account will make explicit what foreknowledge I brought to the research, and outline the reflective process I experienced in preparing and executing this project. The genus of the project and why I chose to research this area will also be outlined.

Willig (2001) describes personal reflexivity which involves exploring how one has informed the research and how the research informs us. To make transparent how I may have influenced the research I will provide some autobiographical details which I consider relevant. I am a Scottish male in my early 50s. I have a personal interest in the topic of health professional and patient relationships and communication. This, my own experience of MI training, and a concern that there was no evaluation planned for a large MI training programme that I was involved with, precipitated my interest in the project.

I work as a Health Psychologist in Training within the NHS. I treat patients with chronic health issues both individually and in group based programmes. The focus of treatment often involves resolving psychological issues, and frequently requires patients to modify health behaviours in order to better manage their conditions. I have completed training in several psychological therapy approaches including person-centered and cognitive behavioural therapies, with some additional training in basic psychodynamic theory and techniques. I also attended three MI training courses: a one-day introductory workshop, a one-day in-service training in BCC, and the two-day cardiac training programme from which several participants of the current study were recruited. The latter is described in detail below. My own experience of these courses was not wholly positive. I was not immediately drawn to the method, nor did I begin to properly understand it and utilize it until I had followed the latter training programme. I performed the role of the patient in the recorded simulated consultations on approximately 50 per cent of the courses. From this perspective, I began this research project curious about how non-psychologically

trained clinicians navigated the learning process, when I personally, with training and clinical experience in psychological therapies and approaches, struggled initially to do so.

During my Health Psychology Doctorate course I have taught on five occasions to peer doctoral students, a nine hour introductory MI course, similar to the cardiac training programme mentioned above. Additionally, I have conducted several half-day and hour long introductory sessions on the topic. In 2010 I was also co-trainer running several MI training courses for multidisciplinary health teams in NHS Scotland. This programme lasted one year with follow-up training days and supervision. Also during my doctoral training I carried out with a peer student, two systematic reviews which evaluated existing MI skill integrity and adherence measures one of which was published in December 2009 (Turner and Wallace, 2009; Wallace and Turner, 2009). It was therefore with substantial foreknowledge and experience of MI and MI training that I embarked on the current research study.

Epistemological position

When I began to orient myself in qualitative methods I questioned whether my pre-existing experiences, knowledge and perceptions of MI and also my relationship with some of the potential participants were problematic and rendered me unsuitable to carry out this piece of research. However it is argued that any research is influenced by the researcher's preconceptions and impartiality, and Yardley (2008) states that these inevitably influence the knowledge and understanding produced by qualitative researchers. Yardley acknowledges and embraces this inevitability and views the researcher's pre-existing beliefs and experiences as elementary aspects of the investigative process. Willig (2001) also argues that in interpretative approaches preconceptions are not 'biases' to be eliminated, but instead are necessary preconditions for making sense of others' experiences.

At first I thought I would have to 'bracket' out my preconceptions and that this would be extremely difficult. However as I read more I came to see that an 'insider's perspective' could be utilized. Smith et al (2009, p. 22-23) state that interpretation

depends on sharing some ground with the person whose experience is being interpreted. Additionally Smith et al suggest that before embarking on a study of how people experience a phenomenon, researchers should question how well they would be able to relate to the potential experiences, concerns and claims of their participants. Smith et al also describe how the interpretive analytic process is non linear and interactional. In this sense they describe how bracketing out foreknowledge is not always possible or desirable, and how at times it works in the opposite direction with one's preconceptions and their relevance only becoming apparent after one has engaged with the data.

Furthermore as discussed above, contextualism emphasizes the relationship between accounts and the situation within which these accounts are produced. Madill et al (2000) state that contextualism recognises that the researcher's personal and cultural perspectives inevitably influence research projects. Madill et al add that the empathy imparted by shared humanity and common cultural understanding is an important link between researcher and participant and a rich analytic resource. Thus in contrast to a realist stance, within a contextualist epistemology the articulation of researcher perspective is not aimed at laying aside biases, rather it allows the reader to understand how prior knowledge may have influenced the analysis and the findings.

With these arguments in mind, along with my strong conviction that the existing research on MI training provided a partial understanding, I began to consider that my own experience, rather than presenting a hindrance, might enhance the investigation into the experiences of learning MI. Indeed true to Smith et al (2009), I did in fact become aware of some of my preconceptions and my own experiences of learning described above only after I had analyzed and interpreted several participants' data.

In considering these epistemological issues, emphasizing context, and recognizing the researcher's undisputed centrality in the research process, my familiarity with respondents and with MI training and practice is rendered non-contentious. This therefore allowed me to approach the project without fear of biasing the findings, but rather enhancing the findings with my prior knowledge and personal experience of so many aspects of the research topic and sample.

Further reflections on my learning, methodological decisions and potential influence on the research process and participants are discussed in Chapter 6.

Contextualising the participants and their work and training contexts

This section describes the study sample and the training programmes they attended. Their demographic data is supplied to help contextualise the study further and allow the reader to judge its relevance to other settings.

Questionnaire participants

Purposive sampling can be used to illuminate a specific research question and to develop as detailed as possible interpretation of the data (Brocki & Weardon, 2006). For the questionnaire component of the study, two local training programmes occurring simultaneously in Cardiac and Substance Misuse services, provided an opportune purposive sample of the multi-disciplinary health professional trainees who attended them. The training programmes were similar and the sample was broadly homogenous since all trainees were experienced health professionals who had attended one of these two programmes.

Participants in the reflective diary component also attended these training programmes but were purposively recruited because they were new members to multi-disciplinary teams with established MI practices. It was expected that they would triangulate the experience of learning MI with those who completed questionnaires. Additionally, it was hoped to further elucidate from these participants, the experience of joining MI skilled teams while awaiting, receiving and consolidation training. It was also considered that their experience may differ from those who return after training to teams where MI is not an established practice.

The recruitment process took place in the first quarter of 2007 and is represented in figure 3.1. The trainers from each training programme E-mailed all their trainees for whom they still had active NHS E-mail addresses, asking for permission to distribute

an invitation to participate in the study. From the Cardiac programme 6 individuals declined leaving 177 who agreed to receive invitations. From the Substance Misuse programme 4 individuals declined and 53 agreed to receive invitations. These 230 individuals were duly sent via E-mail invitations to participate in the study.

Thirteen (7.3%) trainees from the cardiac programme and five (9.4%) trainees from the substance misuse programme consented and returned completed questionnaires. From the cardiac programme a further four individuals consented but did not return their questionnaires, two of whom cited illness as the reason for this.

It is recognised that those are somewhat low response rates, however the uniqueness of the study in terms of its sample and sampling method, its data collection methods, and its context meant that no precedents were available to compare this with. In addition existing literature with comparable samples and methods did not report initial response rates. It was decided not to further inconvenience invitees by contacting those who did not respond again either to try to further encourage them to participate, or to obtain an explanation for why they had not responded: firstly because they had been contacted twice already in relation to the project; and secondly because the participant information sheet explained clearly that they were free to decide not to participate, and it was considered that their choice not to respond should be respected. In addition it was considered that 18 participants completing open-ended questionnaires, combined with 5 completing reflective diaries, would more than suffice this qualitative professional doctoral study. Accordingly it is possible only to hypothesize what the reasons for the low response rate may have been. The following hypothetical explanations have been compiled following in depth consideration, and informal interviews with senior NHS staff familiar with the training, the invited cohort and the timing of the invitations.

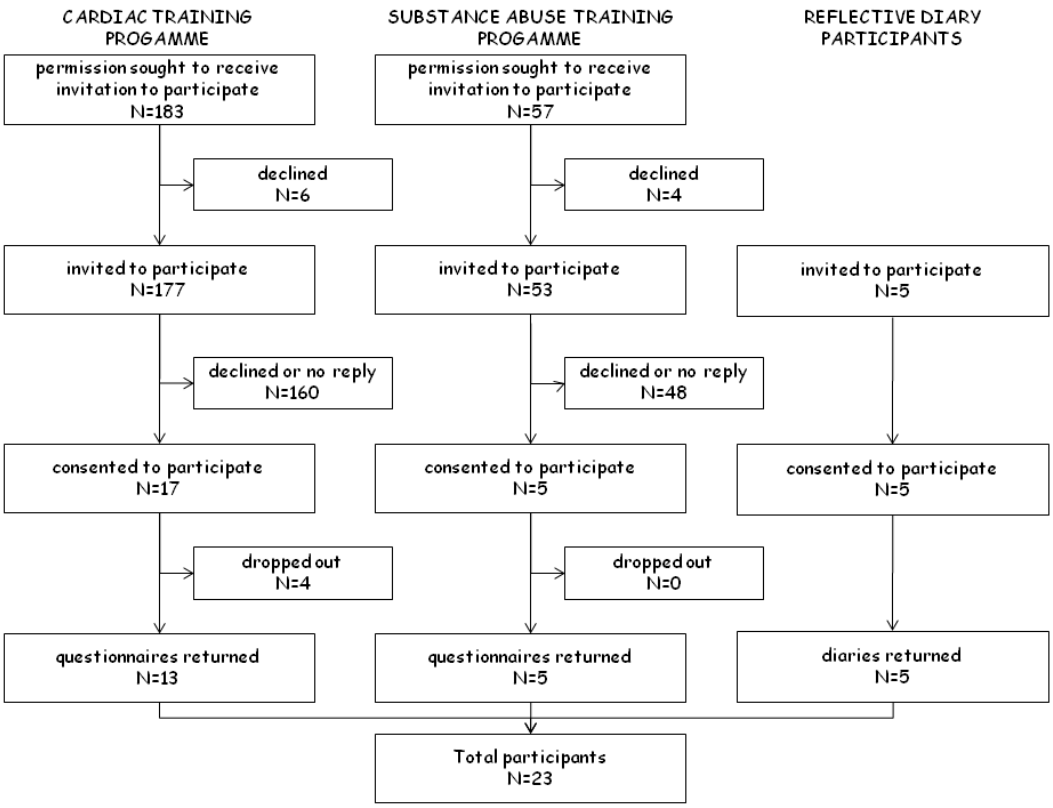


Figure 3.1 Flowchart of recruitment process and participation

The study invitations were distributed at a time when significant changes were taking place within the NHS. 'Agenda for change' had just realigned staff job descriptions and salary gradings, and many were dissatisfied with the results. This, combined with changes to the district nurse and health visitors roles, resulted in an expectation that they accept greater responsibilities for less remuneration. Thus in the NHS professional roles and identities were changing significantly and had led in most cases to feelings of insecurity and disgruntlement. As the findings of this study show MI training can also result in changes in professional identity and a lowering of confidence. Additionally not everyone would have commenced supervision at the time of invitation. It may have been the case that many received their invitation to participate when they had not had time to fully implement the training, and at a time when they felt unable to participate at that stage of their learning. The participant information sheets were very lengthy and this may have been off putting for professionals, who, taking all things into consideration were in a state of 'professional flux'. Some trainees in the cardiac training programme were unable to

find time to complete the case study required for the course, therefore time could have been a factor in non response to a research study information sheet which was lengthy and suggested they would be required to provide responses that may involve 90 minutes of writing.

Few professionals from acute settings responded and it was known that many had indicated that they did not think MI was suited to their role. Professionals in these settings also tend to be younger, more recently qualified, more black and white in their thinking, and more recently trained in an authoritarian consultation style. It is therefore to be expected that the relevance of an MI style may be less obvious at that point.

The NHS E-emailing system was changed during the recruitment phase resulting in a period when some staff were either without emailing facilities and/or were not familiar with the new E-mailing system. Again these conditions may have hindered participation.

Finally, many respondents were acquainted with the researcher and knew that he worked closely with the trainer on the Cardiac Training Programme. Some also knew the researcher as an MI practitioner, from the ‘simulated resistant patient role plays’, and as a co-teacher on some of the cardiac workshops. It should be considered that they may have viewed the researcher as an expert, and this may have introduced power dynamics into the research relationship, and may even have discouraged some from participating. However, Hamilton and Bowers (2006) state that e-mail interviewing can reduce the power imbalance between researcher and participant, and Mann and Stewart (2000) claim that organizational status did not inhibit communication in online communications as it did in face-to-face (FTF) interactions. Therefore, although e-mail interviews as such were not utilized, it was hoped that the decision to use e-mail as the main communication method, would, amongst other benefits discussed later, minimize the potential power imbalance and benefit both the project and the invitees who wished to participate.

One additional individual from the cardiac programme consented. This individual was a Clinical Psychologist who following the MI training became the mentor/supervisor for other trainees. The questionnaire responses from this individual were primarily from this orientation and related more to the experience of mentoring and other trainees' learning, than about the individual's own learning of MI. They nevertheless shed light on the experiences of other trainees and although the individual's data is not included in the findings, the responses contributed to the study and were used to corroborate some of the interpretations made in the analysis and hence triangulated some of the findings.

Participant demographic data and their occupational and training experiences are summarised in Table 3.1. Of the Psychologists, one was a qualified clinical psychologist; the other was in clinical psychology training. One participant labelled their occupation as a generic mental health worker.

No one received financial incentives to participate.

Table 3.1 Demographic Data for Questionnaire Participants

	Course Setting					
	Cardiac		Substance Misuse		Total	
	N	(%)	N	(%)	N	(%)
No. of Participants	13	(72)	4	(28)	18	(100)
Gender						
Female	11	(61)	4	(22)	15	(83)
Male	2	(11)	1	(6)	3	(17)
Profession						
Nursing	4	(22)	2	(11)	6	(33)
Dietetics	2	(11)	-	-	2	(11)
Physiotherapy	3	(17)	-	-	3	(17)
Medicine	2	(11)	1	(6)	3	(17)
Occupational Therapy	1	(6)	-	-	1	(6)
Psychology	1	(6)	1	(6)	2	(11)
Generic mental health worker	-	-	1	(6)	1	(6)
Supervision utilized	7	(39)	1	(6)	8	(44)
Patient Group						
cardiac	11	(61)	-	-	11	(61)
substance abuse	-	-	5	(28)	5	(28)
other	2	(11)	-	-	2	(11)
***(multiple setting)**	(2)	(11)	(1)	(6)	(3)	(17)
Treatment Setting						
acute	2	(11)	-	-	2	(11)
community/primary care	5	(28)	4	(22)	9	(50)
rehab	5	(28)	-	-	5	(28)
mixed (rehab/community)	1	(6)	1	(6)	2	(11)
Time since MI training						
Min	4 months		4 months		4 months	
Max	3 years		10 months		3 years	
Mean	19 months		7 months		16 months	
Years in profession						
Min	3½		6		3½	
Max	26		28		28	
Mean	14		15		11	

all percentages are calculated as percentage of total (i.e.18 participants)
*( ) signifies that participants have already been included in the count for their primary patient group

Reflective diary participants

Five multi-disciplinary individuals who joined existing teams where MI culture and practice was established were invited to participate in the reflective diary component

of the study. All five consented and duly completed and provided diary data. All of these participants were known to the researcher.

Five participants, two nurses, one physiotherapist and two psychology assistants completed reflective diaries on joining new work settings. To protect their confidentiality further demographic data is not reported.

Training Programme Structures and Context

Heeding the contextualist epistemological underpinnings of the study it is important to contextualize the training programmes. This makes more transparent the study's findings, and facilitates assessment of these findings in relation to the participant citations used to illustrate them. In addition, Madson et al (2009) reported that poor description of training courses was a major shortcoming of the training studies included in their systematic review. For these reasons and following existing guidelines for reporting and increasing external validity for behavioural interventions (Davidson et al, 2003; Des Jarlais et al, 2004; Downs and Black, 1998; Glasgow et al, 2002) the training programmes and the trainers are described in detail separately in appendix 3. What follows is a combined overview of the training programmes' structure and content.

Overview of the training programmes

The first training programme was part of a cardiac rehabilitation service redesign in one NHS Trust in Scotland (Todd, 2003). The programme ran from 2004 to 2007 and was a mandatory training for all clinicians in the cardiac pathway of care. This included multidisciplinary staff from acute teams, specialist rehabilitation teams through to clinicians working in the community. In total 23 courses were executed and approximately 200 clinicians attended these. The training course was accredited for degree points.

The second training programme from which participants were recruited was part of a training endeavour in the Substance Misuse Service (SMS) in the same NHS trust in

Scotland which ran throughout the second half of 2006. The training was attended on a voluntary basis. In total 6 courses were run with 57 clinicians attending these.

The workshops for both training programmes took place off site in specialist training accommodation. The content and format of both programmes were typical of those described in the review of Madson et al (2009) addressing MI theory and skills, and both provided optional follow-up mentoring and supervision. The cardiac training comprised two one-day workshops lasting 6 hours each, with an interval of between 1-2 months between each. The SMS training took place over three one-day workshops lasting 6½ hours each, with an interval of 1 week between them. Teaching methods included brief lectures using slide presentations, video recorded demonstrations, discussion, small group exercises and role plays. Mentoring, supervision and support were available on a voluntary basis on completion of both courses.

In the cardiac programme, each trainee undertook an audio recording of a 7-minute simulated patient consultation on the first training day. This comprised the psychologist who was assisting role playing a resistant patient with each trainee. The current researcher performed this role play on around 50% of the training courses. Soon after the initial workshop, the trainees were provided individual written feedback and suggestions for areas to work on between workshops.

The courses were developed by separate individuals, each by a clinical psychologist experienced in delivering therapy using cognitive behavioural and motivational interviewing principles, and, a registered member of the Motivational Interviewing Network of Trainers (MINT). The SMS workshops were delivered by the same individuals who developed the course. The cardiac training workshops were run by the clinical psychologist who developed the course with occasional assistance from other psychologists in training, the current researcher being one of these. Additional course support and supervision was provided by the trainers, assisted, in the cardiac programme, by the clinical psychologist discussed above who provided questionnaire responses from this orientation.

Since the current study is exploring the experiences of MI training programmes regardless of outcome, the attainment of MI skills was not a requirement for participation. The training outcome and procedures therefore will not be described here. They are however described in appendix 3.

Main differences between the training programmes

The developers and trainers of the courses were different individuals. The cardiac training was based on BCC methods and the substance misuse training on full-blown MI methods. The substance misuse training was longer, but the cardiac participants may have received supervision, support and follow-up training at the point of data collection. The substance misuse may have provided more instruction on how to reflect, and more reflective discussion about putting skills learned into practice may have occurred.

Since no difference in experience was identified in participants' testimonials, for the purpose of report clarity both training programmes will be referred to as 'MI training' in the remainder of this report. That those participants recruited from the cardiac training programme did not receive a full-blown MI training should nevertheless be heeded.

3.3 Data Collection Methods

This section will describe the rationale for choosing open-ended questionnaires and reflective diaries as data collection methods. Further considerations relevant to their design and development will also be outlined.

Open-ended questionnaires

Face-to-face (FTF) interviews are commonly used to collect data in qualitative experiential research. This method was deemed inappropriate for the current study due to the participants being known to the researcher, their potential geographical

dispersion, and due to time and other resource constraints. Additionally, in a health service that has increasing demands placed upon it, it was considered interesting and valuable to explore the utility of written and electronic data collection methods which are flexible, economical, and relatively straightforward to administer.

Turner and Coyle (2000) and Murray (2004) used E-mail methods with IPA. Murray (2004) found that in contrast to FTF interviews, participants interviewed by E-mail produced more frank, focused, and reflectively dense accounts. They postulate that this may have been due to the extra time available to reflect on questions before responding. E-mail interviewing was considered for the current study, but it was decided that even with only a small number of participants this would involve many interactions over some time, and, that it would quickly become cumbersome and time consuming for both the respondents and the researcher.

Turner and Coyle (2000) utilized E-mail to collect data via semi-structured questionnaires. They reported that the richness of the data collected suggested this method bridged the gap between postal questionnaires which can be perceived as impersonal, and FTF interviews which create an empathic relationship which is comforting for participants and encourages sensitive disclosure. Patton (2002) states that open-ended questionnaires provide the most elementary form of qualitative data. Patton lists problems that may be associated with collecting open-ended questionnaire data in written form. These include limitations that may arise due to the writing skills of participants; problems with the inability to probe further or to request elaboration of responses; and the effort required of the participants in completing the questionnaire. However for the current study, health professionals were considered likely to be highly literate and potentially motivated to contribute to the research topic, and utilizing E-mail distribution methods would allow probing if this became absolutely necessary. Additionally, Patton provides an example where open-ended questionnaires reveal rich and detailed emotions. Taking into consideration this and the limited time and resources available, it was concluded that an open-ended questionnaire might serve the aims of the current project well.

The questionnaire would be distributed and returned via E-mail as this would bring many of the benefits of E-mail interviewing and would be a fast, simple, secure, confidential and familiar mode of communication for all invitees who were accustomed to using the NHS E-mail service. It would also reduce printing and postage costs. There exists a paucity of literature relating to online and E-mail methods but the scant literature relating to E-mail interviewing (Hamilton and Bowers, 2006) informed this decision and design. Using E-mail to gather data via open-ended questionnaires would also provide exploratory data relating to the utility of this method of qualitative data collection in health and clinical settings, and for a TA approach.

Additional benefits associated with asynchronous online data gathering methods were also desirable. Clarke (2000, p. 7) researching online qualitative research methods cites: Murray and Sixsmith (1998) who reported that online communications result in more truthful answers, particularly when respondents are asked to reveal sensitive personal information; Levinson (1990) who considers that asynchronous electronic communication's ability to provide the opportunity for reflection and editing of messages prior to sending them, results in a closer match between thoughts, intentions and their expression in writing; and Hiltz and Wellman (1997) who suggest that not having to wait for turn-taking, as required in FTF interactions, provides more equality of participation to more reticent respondents.

Online interviews have been described as providing advantages such as: the reduced need for travel; the lack of transcription costs; their ability to include those who are geographically and socially isolated; and their ability to counteract concerns about anonymity and disclosure (Davis, Holding, Hart, Sherr, & Elford, 2004; Mann & Stewart, 2002). E-mail data collection methods would also provide these advantages and allow professionals to choose where and when to construct their answers allowing them to fit their participation into their busy schedules. Additionally it would mean that they would not have to discuss responses face-to-face with a researcher who was known personally to several of them.

Davis et al (2004) report disadvantages of synchronous online interviewing relating to technical limitations and social conventions of computer-mediated communication (CMC) and the ambiguity that these may introduce into an online dialogue. Such CMC conventions include mixed prose-style, textual abbreviations, and staccato or pointed dialogue. Using questionnaires transmitted via E-mail would allow the professionals more time for reflection and elaboration and hence, as suggested by Davis and colleagues, potentially overcome some of the disadvantages reported for synchronous online interviewing. Electronic questionnaires and E-mail would also provide automatic text transcripts and an audit trail of all responses and communications.

Questionnaire design

The research process involves interplay between induction and deduction, and TA can be utilised for both approaches (Braun and Clarke, 2006). Here an inductive approach was taken therefore the data collection methods should be flexible enough to permit unanticipated topics and themes to be derived during analysis (Smith, 2004). In developing the questionnaire particular effort was therefore made to ensure the questions were as generic and open as possible, and to encourage the participants to respond openly and expansively.

A balance had to be maintained between keeping the number of questions small and gaining sufficiently rich and varied information that would inform the research questions. This would necessarily entail numerous aspects of an individual's experience such as feelings, thoughts and behaviours. Although not completely unavoidable, it was desired that, prompting for information and elaboration would be kept to a minimum. To avoid one dimensional responses, questions were designed to ask about one aspect of learning MI, with prompts included after most questions asking participants to consider emotional, cognitive, behavioural, temporal and contextual aspects of their experience. The eight-item questionnaire can be seen in appendix 2.2

Following Patton's (2002) advice on clarity, no MI concepts or jargon were mentioned in the questionnaire. In addition to providing clarity, this would imply that any jargon or specialist terms found in responses would therefore indicate knowledge of these and their salience for participants.

The closing question of the questionnaire was constructed directly from Patton's ideas about how to close an interview by giving the interviewee the final say. Patton's suggestion to ask, "what should I have asked that I didn't think to ask?" (p. 379) was included in the prompt for this final question.

The questionnaire was piloted using non participating colleagues and a fellow researcher. This highlighted some potential for misinterpretation and the questionnaire was revised accordingly.

NHS ethics boards require researchers to discuss in their applications for ethical approval, what benefits or costs may arise for participants in a research study and suggest that they should be informed of this before they consent to participate. No similar research studies were found prior to conducting the study therefore no precedent existed to help in answering this important question. To help inform future researchers therefore, a final question was sent via E-mail when completed questionnaires were received. This question asked "*What positive and/or negative effects has taking part in the study had for you?*". This was not included in the original questionnaire as it was considered its presence might influence the research process and bias the responses it instigated. The fact that participants responded to this question without complaint and often with gratitude for allowing them the opportunity to participate suggests that this final unexpected question was not offensive. This additionally highlighted the strong motivation for these health professionals to contribute to MI training knowledge and theory.

Reflective Diaries

Bolger, Davis and Rafaeli (2003) and Richardson (1994) discuss the advantages and limitations of using diaries in research. Although they describe primarily diary methods for collecting quantitative data, some of their claims are relevant to the current study. They assert diaries are self-report instruments which when used repeatedly can allow the exploration of ongoing experiences, and, provide an opportunity to examine social, psychological, and physiological processes within everyday situations. Concurrently, diaries acknowledge the importance of the contexts and settings in which these processes unfold. Bolger and colleagues state that diary methods may provide data complementary to that available through more traditional methods. Diary data can be rich, detailed and intimate and can overcome many of the disadvantages associated with retrospective data collection methods (Richardson, 1994). Bolger et al also suggest that diary studies that investigate major events such as occupational transition are powerful as they target participants when their environments are instable or changing. These attributes of diary methods make them apt in the current study.

The diary component of this study was conceived to complement the questionnaire component which ran the risk of producing cursory responses. It was therefore envisioned that the reflective diary data would elaborate and triangulate the findings from the questionnaire study.

Another aspect of diary methods that would complement the study is their ability to reveal how events unfold prospectively and in real time. In the questionnaires most participants would be recollecting experiences. Drawbacks of retrospective reporting include that it may be influenced and biased by current circumstances and psychological states, through retrospective interpretation of events, or simply through forgetting details (Bolger et al, 2003; Willig, 2001). Due to the reduction in time elapsed between an experience and the participants' accounts of this experience, the diary method reduces the likelihood and drawbacks of retrospection.

Related to this, an additional benefit relevant to the study is that diaries allow examination of temporal dynamics (Bolger et al, 2003; Richardson, 1994; Willig, 2001). Consequently they could provide insight at the temporal level of interpretation as described by Smith (2004), and could therefore enhance the analysis. Additionally Bolger et al claim that diary data can help uncover antecedents, correlates, and consequences of experiences, and in this way data gathered by this means might elucidate or inform findings relating to process. Smith (1999) claimed that the longitudinal nature of diaries allowed process to be studied. It was therefore also hoped that the diary data may shed some light on processes experienced when learning MI.

One drawback of diary methods is the burden they place on participants (Willig, 2001). The diaries used here were to be reflective in nature. Reflective practice is now encouraged within the health professions. The importance of reflection in learning new skills has also been highlighted by the adult learning and MI training literature. It was therefore surmised that what the exercise asked of participants would be beneficial, and for some would be no more than would be required in their daily practice and in particular following training if the above adult and MI training literature was heeded. It was also surmised that a secondary insight that might emerge with this method was the degree to which participants could appropriately utilize reflective diaries. In this way the appropriateness of participants' existing reflective abilities might be explored and conclusions drawn and recommendations made concerning the degree to which future training programmes may need to include some training or guidelines on methods of reflection.

Willig (2001) describes limitations of the diary method including poor recruitment and high dropout rates and that success depends on participants' motivation and commitment to the research. Willig also discusses ethical considerations relating to how completing diaries might sensitize participants to negative aspects of their experience. These concerns were not seen as problematic in the current study as again the diaries were to be used reflectively with the aim to develop awareness and to bring about change. In this sense the reflective diaries should bring to light both

negative and positive experiences and then hopefully facilitate constructive changes in experience. Willig's concerns were nonetheless heeded and support was available had participants required it.

Richardson (1994) discusses other limitations of diary methods which either weren't relevant, or were non problematic in the current study as they are inherent to most qualitative research projects. These include: tool construction time; bias that may be introduced by excluding those who are not literate; and high costs and complexity of data collection, processing and analysis.

In summary the diary component was included in the study to provide prospective data to complement the retrospective questionnaire data, and to triangulate findings by using another data collection method and time dynamic.

Further considerations of relevance to both questionnaire and diary methods

All invitees were invited via their NHS E-mail addresses. It was therefore considered that all were able to access and utilize E-mail and basic word processing packages, and that their reading, reflection, writing and computer skills, all recognized limitations of computerized data collection (Davis et al, 2004), would not limit their ability to participate. Additional limitations such as the loss in electronic communication of sound and visual cues, such as tone of voice, pauses and body language which commonly supplement FTF communication, were considered to be outweighed by the benefits otherwise gained by online data collection for this study.

Criticisms have been made relating to transcription reliability (Kvale, 1996) and transcription practices which '*tidy up*' data and remove it from its '*raw form'* (Seale, 1999). Further advantages reported for E-mail interviews that were also relevant to both data collection methods included the elimination of transcription errors, the ease with which an audit trail of the communications between a researcher and the

participants can be created, and the enhanced external validity that this would bestow (Hamilton & Bowers, 2006).

3.4 Data collection and data analysis procedures

In this section the data collection and data analysis procedures and processes will be described.

Data Collection Procedures

Depending on which component of the study was relevant to them, all trainees were sent via their NHS E-mail system either the questionnaire or the diary participant information sheets. These invited them to participate and provided information about: what participation would involve, an estimate of the effort and how long it may take to compete the questionnaire or diary, consent procedures, confidentiality, available support, and withdrawal procedures (see appendix 2.1). Those who wished to participate were asked to print and sign two hardcopies of the consent form and to send one via NHS internal mail to the researcher and to keep the second for their own records (see appendix 2.1). Informed consent was obtained in this way since according to Hamilton and Bowers (2006) a hardcopy would establish a more concrete and less *'virtual'* association with respondents, adding a layer of protection and contact for both researcher and respondents, thus creating more steps in the research process, and, so, minimize opportunities for data fraud. A request for permission to publish data extracts was also included on the consent forms.

On receipt of their consent form participants were allocated a unique Participant Reference No. This was used to store their data electronically on the secure NHS Local Area Network (LAN) after all identifying data was removed. The consent forms and any hardcopies of data were kept locked in a cabinet in the researcher's NHS place of work.

Participants in the questionnaire component were then sent via E-mail a Participant Information Questionnaire and an Open-ended Questionnaire (see appendices 2.1

and 2.2). The background of the study was again explained and instructions for completion were included. The participants were asked to complete these questionnaires within 2 weeks and return them via E-mail to the researcher.

Those participants completing reflective diaries were also sent via E-mail a Participant Information Questionnaire, and were asked to send to the researcher their diaries via E-mail on a weekly basis for a period of between 2 and 3 months depending on the opportunity they had to practice MI and the degree to which they found keeping the diary a personally useful exercise. If reflection was needed to learn MI as the literature suggests, then it was considered interesting to see how participants completed the diaries without training or instruction. Hence detailed instructions on how to complete the diaries were not provided. Some introductory material on reflective practice was however supplied.

On receipt of questionnaires and diaries, the researcher checked to make sure they were complete. Following Hamilton and Bowers (2006) suggestions for protecting confidentiality when using online data collection methods: all E-mail content was copied into word documents and saved in the researcher's personal secure folder in the NHS LAN after adding the respondent's unique Participant Reference No., and after removing all other identifying information. E-mails were then deleted and the E-mail 'trash' folder emptied. Thereafter the steps for protecting confidentiality are no different from data collected via more conventional methods. The participants were then thanked via E-mail for their contribution, and the additional question was posed asking how they had experienced their participation in the study. On receipt of the reply to this question they were again thanked for their participation.

Hamilton and Bowers (2006) warn that participants need to be clear that they can withdraw from the research study at any time, and that with online methods researchers need to be extra vigilant due the absence of visual cues. Being cognizant of this, those who did not reply within 2 weeks were sent an E-mail reminder indicating that their contributions had not been received, and that they could still contribute if they wished. A reminder that withdrawal was also possible was also included in this E-mail. Following several participants' responses, their participation

period was extended and their data was duly received. Two trainees requested to be withdrawn due to illness, and a further two did not reply and were assumed to have withdrawn.

Although the diary participants were invited to send the researcher via E-mail, their diary entries weekly for a 2 or 3 month period, this did not occur. Few instalments were received on a weekly basis and the researcher had to issue frequent E-mail and FTF reminders. Adding to their warning above Hamilton and Bowers (2006) state that, the longitudinal nature of asynchronous E-mail interviews calls for the researcher to attend cues that may suggest that participants are becoming uncomfortable with the process, and to regularly seek assurance that they wish to continue. Considering the reflective diary component of the study was indeed 'longitudinal and asynchronous' in nature, and that it placed some demand on participants, the researcher was particularly vigilant of their continuing desire to participate. E-mails and FTF discussions were utilized frequently to check their participation stances. Although most participants found the utility of their reflections reduced over time, and that their workloads resulted in them finding little time available to complete their diaries, they were nevertheless keen to continue to contribute.

One diary participant, who would return to their previous place of work, requested that they may contribute after returning to their own service as they wished this experience to be documented too. As analysis had not commenced at this point, permission was granted for the participant to do this. Ultimately all five participants provided reflective diaries. The duration of the reflections ranged from between 8 and 50 weeks, and the number of instalments ranged from 4 to 14.

A time span of approximately one year elapsed between data collection and the beginning of the analysis stages

Data analysis processes

In this section, the TA process used to derive, consolidate and interpret themes will be described.

Analysis process used to derive themes

The analysis was executed based on guidelines for TA produced by Braun and Clarke (2006) who emphasize that the approach is not prescriptive; rather they provide a set of flexible guidelines, which can be adapted by individual researchers in light of their research aims. This flexibility suited the current small scale study as the amount of data collected and themes that emerged unexpectedly became extensive and potentially overwhelming. A pragmatic approach was adopted which adapted the guidelines and allowed the scope of the project to remain contained and manageable.

The procedure adopted in this study involved treating the Questionnaires and Diaries as one set of data. The analysis began with what was considered to be a more detailed and rich questionnaire. The process outlined below was carried out for this case then repeated for a further six questionnaires and two of the longer diary scripts. At this point, it became obvious that the data was becoming overwhelming and difficult to manage. A decision was then made to analyze the remaining scripts in detail, but only new themes and salient examples of the themes that had already been derived were recorded. Source texts and themes were recorded and analyzed using Microsoft Word and Excel.

The following stages were executed for each case throughout the analysis. The transcript was first read several times and notes were made of anything that appeared relevant to the experience of learning MI. Next the transcript was read anew and the initial notes and ideas were transformed into initial codes. Next more specific and concise themes or phrases which captured the essence of the text were generated. An attempt was made to find a connection and a balance between theoretical abstraction and interpretation, and a preservation of the particularity of what was specifically being said. The next steps were more interpretive and involved analyzing and exploring connections between concepts and documenting key themes, key actions, their origins, and their consequences. Smith (2004) discusses social comparison, metaphorical and temporal levels of interpretation and these were all utilized. The

resulting themes were then clustered together into related groups and super ordinate themes.

The above process was repeated for each transcript. As already discussed, with the ninth and subsequent transcripts only new themes and salient, rich examples of existing themes were recorded. The analysis for each was nevertheless in every other way as described above. When new themes or interpretations were identified, previous transcripts were reread to check for evidence of these. The analysis progressed in this iterative fashion until all cases had been analyzed, resulting in a set of individual and shared themes for the data set.

In TA salience of a theme can be determined by its occurrence across the data set. However it is emphasized that TA is flexible and the "keyness" of a theme is not necessarily dependent on prevalence but can be determined by its relevance to the research question and by researcher judgment (Braun & Clarke, 2006, p. 82). In the current study repetitions of the themes across individual transcripts were taken to indicate their salience in the experience of the participants in relation to the topic under investigation. However as this was a qualitative, TA analysis, no hard-and-fast rules were applied relating to what proportion of the data set needed to display evidence of the theme for it to be considered a theme. Additionally in line with Braun and Clarke, the "keyness" and therefore inclusion of a theme was also based on the researcher's judgement of its relevance to the research question and to future MI training theory and practices.

When all transcripts hade been analyzed a deviant case analysis (Silverman, 2005) was performed to establish whether exceptions as well as typical examples of developing themes and theory could be explained. This analysis can increase the internal coherence, and hence, the quality and validity of an analysis (Madill et al, 2000; Yardley, 2008).

Following Braun and Clarke's (2006) suggestion, a graphic representation of the themes and their interconnections was drawn (see figure P.1). A narrative account of the findings was produced ensuring that the integrity of what the participants said

had been preserved. Salient themes were then linked to the extant literature. A data audit was also created enabling the analytic journey from the raw data through to the end narrative to be tracked.

Analysis continued throughout the compilation of this report. During this phase further links were noticed and due to learning new ideas from the extant literature, further interpretations were made, and the developing thematic framework was consolidated and extended. Finally rich data extracts were selected to illustrate the resulting themes.

3.5 Ethical Considerations

Full NHS ethics was applied for and the ethics board who reviewed the application deemed the project an evaluation study which therefore did not require full ethical approval. The project was also approved by the Queen Margaret University Ethics Board and Ethical guidelines of the British Psychological Society (British Psychological Society (BPS), 2006) were followed at all times.

Although the current study was not internet based or conducted online, there are nevertheless some characteristics of such research which are relevant. The nature of online research poses additional ethical concerns, and supplementary guidelines for conducting ethical research online have been proposed (BPS, 2007). A key concern with online research and the current study is the lack of physical contact between the participant and the researcher. This raises concerns about identity and about recognising distress or adverse reactions experienced by a participant.

Participants' identity was verified and the potential for identity fraud minimised through inviting known MI training course attendees, and through using participants' NHS email addresses and accounts. These are password protected, and controlled by NHS security policies which require employees to logoff computers when they are not physically in use.

In relation to identifying distress the participant information sheets explained participants' right to withdraw, and instructed them to contact the researcher, the NHS, or the university if they experienced problems. Participants were reminded of this in email correspondence and the final question provided the opportunity to highlight any problems that arose. The participant information sheets were also particularly detailed aiming to achieve 'informed' consent which was obtained via consent forms before the study began. How this was achieved and how anonymity and confidentiality (which also require additional consideration in online research) was protected has been described in detail in section 3.4

3.6 Evaluative criteria

Several guidelines exist for assessing the quality of qualitative research which it is argued cannot be assessed using the same criteria and concepts used for quantitative research. Additionally qualitative methods are diverse and varied and therefore such guidelines need to be broad ranging and flexible. Several guidelines exist which attempt to consolidate many of the theories, ideas and strategies that are purported to enhance quality in qualitative research while remaining flexible enough to be relevant to various qualitative approaches. Three such guidelines (Elliott, Fischer and Rennie, 1999; Lincoln and Guba, 1985; and Yardley, 2008) have been adhered to throughout this study. These guidelines have much overlap and the following described how Yardley's guidelines have been adhered to.

Collating criteria for assessing quality, Yardley (2000) devised a framework for assessing quality whose dimensions include: *sensitivity to context*, *commitment and rigour*, *transparency and coherence*, and *impact and importance*. The characteristics of these dimensions are summarised table 3.2. How Yardley's criteria are addressed will now be outlined.

Firstly, Smith et al (2009) claim that an idiographic approach, such as that used in the current study, acknowledges *sensitivity to context*. This is also addressed by the fact that MI training and adult learning theories, and the theoretical underpinnings of the

TA and the rationale for using them are outlined, and that from this, specific research questions were formulated. Sensitivity to participants is conferred by allowing them the choice to participate, and by using flexible data collection methods which allowed them to choose when to write their responses and what to disclose when they did. The effort made to ensure the questionnaire was as open-ended as possible also shows this sensitivity, as was the systematic repetitive method of analysing and making sense of the raw data. The use of participants' verbatim extracts, allowing their voices to be heard, while allowing the reader to assess the researcher's interpretations also confers this criterion. Sensitivity to the socio-cultural setting is addressed by the detailed contextualising of the training programmes, and the descriptions provided of the participants' and the researcher's background and stance.

Table 3.2 Yardley's Quality Assessment Framework
Characteristics of good (qualitative) research. Essential qualities are shown in bold, with examples of the form each can take shown in Italics (adapted from Yardley (2000) and Yardley (2008))

Sensitivity to context *Relevant theoretical and empirical literature; empirical data; socio-cultural setting; participant's perspectives; ethical issues.*
Commitment and rigour *Thorough data collection; in-depth engagement with topic; methodological competence or skill; depth and breadth of analysis.*
Transparency and coherence *Clarity and power of argument; fit between theory and method; transparent methods and data presentation; reflexivity.*
Impact and Importance *Theoretical (enriching understanding); socio-cultural; practical and applied (for community, policy makers, health workers).*

It relation to *commitment and rigour*, Smith et al (2009) state that addressing commitment can be synonymous with demonstrating sensitivity to context. Rigour relates to the thoroughness of a study. Rigour is shown here, as the sample chosen is relevant and appropriate to the research question, and it is homogenous in that they all had in common the experience of MI training. The data collection methods were also rigorously managed. Rigour is also addressed through the thorough and systematic data analysis and with sufficient idiographic focus on individual cases. Additionally that some findings are not just descriptive but interpretative confers rigour. Finally that the participant extracts used to illustrate themes were from a wide range of participants, and selected from examples from the entire corpus also confers rigour.

Transparency has been addressed through the detailed description of the research stages from study conception, through design, to analysis and write-up. Describing the training programmes, the participants' and the researcher's reflexivity also contribute to this criterion. *Coherence* is conferred by the fit between the research question, and the theoretical underpinnings of the TA. Additionally an awareness of the interpretative nature and potential incompleteness of the findings are discussed,

and by contextualising the study in detail and describing the researcher's stance, the reader can better interpret the findings. The findings and arguments reported are also coherent in that they are plausible, they hang together logically and the contradictions in the deviant case have been outlined and explained.

In terms of *impact and importance* it is hoped that the study will resonate and be relevant to other trainers and researchers, and will contribute to MI training and other therapeutic training endeavours in both theoretical and practical ways.

Yardley (2008) describes further procedures which when relevant and carried out enhance the validity of qualitative research by improving the depth, breadth and sensitivity of an analysis. Those that are relevant to the current study include triangulation, deviant case analysis and generating a paper trail, and their applicability to the current study will now be discussed.

Yardley (2008) describes how triangulation, rather than attempting to converge on a single consistent account, instead enriches the understanding of a phenomenon by examining it from different perspectives. Flick (2006) citing Denzin and Lincon (2000) thus conceives triangulation not as strategy for validating findings, but as an alternative to validation which can be used to increase "scope, depth and consistency (p. 390)". Triangulation can be achieved through gathering data from different groups of people, from different perspectives at different times, and through utilizing different theories or methods. Triangulation conceived in this way is abundant in the current study. It is achieved:

- through the recruitment of multi-disciplinary professionals, from different MI training programmes, from three different health settings (substance abuse, cardiac and chronic pain), and within varying timeframes since their training;
- by utilising two data collection methods;
- with the corroboration of experiences from the point of view of the clinical psychologist who supervised trainees;
- in the researcher's own perceptions and experiences of MI training and practice;
- through the deviant case analysis (discussed further below); and finally

- by corroborating and enhancing the findings of existing quantitative and qualitative research into MI training.

Smith et al (1999) also recommend discussing emerging analytic ideas with peers and other researchers, as articulating ideas may help to identify relationships between themes. Although this was not a planned strategy this occurred spontaneously during meetings unrelated to the current project about future NHS staff training. Attendees included NHS service and training managers, and their experiences and concerns relating to health professionals' training echoed some of the current study's findings. They also recognized and validated many of the salient themes raised by the researcher. These interactions also provided a form of triangulation of the findings.

Yardley (2008) suggests that performing a deviant case analysis increases the quality of an analysis by reassuring the reader that all data has been taken into account and presented. This analysis can provide disconfirming findings and an indication of the limits of the generalizability of a study. As described in Chapter 4, the deviant case in this study had not utilised many of the reflective practices that facilitate learning MI and in fact her experience confirmed many of the findings drawn from the other participants' reports.

Yardley (2008) suggests that a paper trail enhances quality by providing evidence linking the raw data to the final report. An electronic audit trail was created for the current study from initial data gathering through to the final write up. This is enhanced by the fact that no data transcription was necessary due to the data collection methods utilised. Although an independent audit was not performed this audit trail provides the means for doing so.

According to Charmaz (2006, p. 113) saturation occurs when 'fresh data no longer sparks new theoretical insights'. Although in an interpretative, contextual study saturation was not an aim, rigour is further enhanced in the current study by the fact that saturation of themes occurred when no new theoretical insights were obtained from the latter cases analysed.

Finally, although due to the elapsed time between data collection and analysis member checking was not performed, this is not always necessary or appropriate for qualitative studies. Nevertheless, the additional question posed to participants provided the means for participants to provide feedback on how they experienced the research process. Detailed findings derived from this data are outlined in appendix 4.1. These showed that participation in the current study was a positive experience. In summary it was reported that participation resulted in reflection which consolidated and restarted their learning process.

Chapter 4 Findings

Contents

4.1 Themes relating to clinicians' experience of learning MI

The following describes the main themes obtained from the analysis of participants' questionnaires and reflective diaries relating to how they experienced learning MI. The views and experiences relating to how health professionals learn MI expressed in this study, can be organised into five main themes. These and their sub-themes are listed in table 4.1 and are outlined in detail below. Convergence and deviation from extant theory and literature, and the implications for future theory, research and training will be discussed in Chapter 5.

Extracts from participants' writing have been used extensively to illustrate the themes, with an emphasis throughout on letting the participants speak for themselves using their own words. All extracts are transcribed verbatim, including spelling and punctuation errors and identified using their unique Participant Identifier No. whose format is explained in appendix 6.

Table 4.1 Main themes and their associated sub-themes

Emotional Roller Coaster • Anticipation and optimism • Worry relating to role play • Fears and negative expectation of others • Ambivalence relating to future role • Anxiety subsides with experience • Disappointment, disillusionment, and lowered mood
Professional Identity Shifts • Fragility and vulnerability of professional identity • Professional identity and confidence fluctuations • Self-consciousness and 'clumsiness' • Quiet change and skill development • Moving from unconscious to conscious awareness of skills • Building trust in MI methods • Confident growth in professional identity

Challenges and Fears • Old habits die hard • Mental overload • Directive vs non-directive clinician • Concerns over sensitive disclosure • Patient characteristics and clinical contexts • Time limitations • Lack of confidence • Work environment and culture
Experiential Learning • Roles plays facilitate learning • Content, structure and feedback • Access to appropriate clients and their feedback • Modelling and learning by example • Developing reflective practices • Follow up training and support
Personal and professional gains • Benefits clinicians and clients • Applicability and flexibility • Cultural change

Theme 1. Emotional Roller Coaster

Learning MI was an emotionally and psychologically challenging experience for clinicians before, during and after their training courses.

Clinicians experience a mix of positive and negative emotions as they contemplate their courses. They experience excitement and anticipate learning a new consultation style which will benefit their clinical practice. They also experience anxiety about the course content, the potential of feeling deskilled and this being witnessed by others, and ambivalence and sometimes annoyance that they have been requested to do the course

In summary learning MI and HBC methods is an emotional experience with highs and lows. This roller coaster influence on emotions and confidence is highlighted in the following diary extracts.

> *it was a rocky journey with my confidence decreasing then increasing, so very up and down.*
> (DNU04)

> *Although I came away from the session feeling somewhat drained and frustrated to many of her responses (although this was more related to how negative she was which she just couldn't see) I thought it was a real achievement for me to be able to have that sort of discussion with someone where I felt I knew what to say and how to direct the conversation where 11months ago I would have been completely stumped. It was hard work but somewhat satisfying and gave me a sense of achievement.*
> (DNU05)

Anticipation and optimism

In contemplating their MI training clinicians considered their current practice and reflected on areas that might be improved.

> *I felt cautious optimism in the beginning as I had no previous experience of any training of this kind and was looking forward to the opportunity to learn new techniques to enable me to assess and treat patients more effectively.*
> (QPH16)

Worry relating to role play

These positive experiences were often accompanied by more negative emotional experiences. Anxiety was frequently expressed in relation to the role plays that would be part of the course work, in particular those that would be recorded.

> *Once I was aware that I had to do a 'role play' that was going to be recorded, I think I lost sleep worrying about it as well as feeling physically sick about doing the role play*
> (QPH16)

Fears and negative expectation of others

Another common concern reported by clinicians related to fears before the training that they would become deskilled, lose confidence, and that their skills and professionalism would be judged and questioned by others. The role plays could be considered opportunities for these deficits to be revealed to others and these concerns may explain some of the anxiety relating to role plays.

> *I attended this training with a feeling of anxiety, fearful that techniques that I had been using were wrong or in fact that I couldn't actually use them correctly. I value my ability to enable and empower people and view this as fundamental to the support/care that I offer. I feared that I would be found out, that in fact I was kidding myself that I could enable /empower people to make changes to their lifestyles and I was worried that I would loose my confidence in this area of practice.*
> (QNU02)

Annoyance is also expressed in relation to these concerns.

> *I was very nervous and worried a lot about how others on the course may judge my abilities to do my job. I thought that my practise was probably ok but that there was room for improvement but was concerned that others may think that I should be an expert. Maybe also a little annoyed that I had been deemed OK to do my job and now I needed trained.*
> (QNU03)

Ambivalence relating to future role

In the previous extract annoyance is directed towards management or 'those that decided the training was necessary' and this along with cynicism and concern about relevance and implications for professional roles were expressed in relation to having been asked to complete the training.

> *Intrigue – what is it? Cynicism – is it a bit touchy feely? Bemusement – why was I "volunteered" for this?*
> (QDR12)

> *Initially there was the consideration that as a physio this was not my role, more a counsellor's role + I was concerned this may open the door to difficult situations that I would not be experienced enough in dealing with.*
> (DPH01)

Pre course ambivalence and uncertainty about the training is summed up well in the following extract.

> *I was interested in learning more about specific communication techniques as I had previously heard of HBC but didn't know much about it. My previous knowledge led me to believe that the course would be very theoretical with less emphasis on the practical element. I was unsure how applicable the techniques would be in clinical settings. I was hoping that my communication skills would be improved through the coursework but was anxious about the initial 'mock interview' as I felt this would only highlight poor aspects of my communication and was unsure how this could benefit my progress.*
> (QPH17)

Anxiety subsides with experience

Many participants commented on the fact that much of these concerns were either not justified in retrospect or subsided quickly during the workshops.

> *I suppose, if I'm honest, I had some fears about role play and demonstrating my understanding (or lack of it) in a group setting. In context, these were not great and in fact, as I expected, were pretty groundless.*
> (QGP04)

Much was written about the experience of role plays. For some, the role plays were challenging but got easier with practice and they were seen by many as beneficial. Seeing the trainers partake in role plays also alleviated anxious and awkward feelings.

> *The role play always makes me feel a little daft but I think because there was so much of it, it really helped. The daftness soon passed and it gave great opportunity to practise techniques but also to experience how a client may feel and respond in certain situations. I think it was an invaluable aspect of the course.*
> (QNU03)

> *I was apprehensive about the actual training as I hate role play but the way the trainers demonstrated things themselves helped take the pressure off.*
> (QNU22)

Disappointment, disillusionment, lowered mood

During the course and practice exercises, many clinicians commonly experienced a shift in their professional identity (discussed in Theme 2 below) with the realization that consultations could be improved. For some, a stronger reaction results when

clinicians experience a lowering of mood and confidence and may question the efficacy of their previous professional interactions.

> *I was aware my practice did have elements and examples which were classic mistakes, highlighted by the course discussion, videos and teaching. This made me feel rather low actually.*
> (QNU13)

> *Disappointment (slight) – that I hadn't had opportunity to use this in the past*
> (QDR12)

After the course frustration and worry can arise in relation to remembering and using the skills taught.

> *Frustrating – when I can't remember which strategy to use*
> (QDR12)

Theme 2. Professional Identity Shifts

Clinicians commonly experienced several shifts in their professional identity. Firstly they experience feeling deskilled and this brings a lowering in confidence, and for some as discussed above a lowering of mood. Over time and with practice, feedback and reflection, skill development is recognised and this brings an increased sense of professional identity.

> *I was worried that I wouldn't be able to remember all of the principles to use them effectively in my practice. I realised that my interviewing style could significantly be improved.*
> (QDI06)

> *In relation to my clinical practise my Consultation style has changed I think I am more effective at empowering patients*
> (QDR12)

> *I feel more confident in tackling the trickier issues and will be more persistent in trying to unpick underlying issues by using the techniques learned. I feel I am able to be more direct in general but remaining respectful of the patients agenda. Hopefully I have gained respect from patients by going about things in a slightly different way. I think that there is more respect from my colleagues as I think my overall assessment skills have improved significantly as well as my ability to carry out effective goalsetting sessions.*
> (QPH16)

Fragility and vulnerability of professional identity

As already mentioned above, a common concern reported by clinicians related to fears before the training that they would become deskilled, lose confidence, and that their skills and professionalism would be judged and questioned by others In the following extract the fragility and vulnerability of professional identity and confidence is evident, here, even before the training begins.

> *I attended this training with a feeling of anxiety, fearful that techniques that I had been using were wrong or in fact that I couldn't actually use them correctly. I value my ability to enable and empower people and view this as fundamental to the support/care that I offer. I feared that I would be found out, that in fact I was kidding myself that I could enable /empower people to make changes to their lifestyles and I was worried that I would loose my confidence in this area of practice.*
> (QNU02)

Professional identity and confidence fluctuations

During the workshops two things were commonly experienced. Firstly trainees recognized that the MI principles and techniques could improve their practice and hence client outcome. This was often accompanied my excitement and interest.

Some clinicians were able to incorporate the techniques quickly into their practice and experienced increased confidence from this.

> *When the trainer was providing information on HBC techniques, a lot of it made sense. It gave theory to some of the things we might have discussed in goal setting. I found the tools useful and was able to start using them right away. E.g. asking patients about their levels of confidence and importance in change. The change cycle was helpful in gauging patient's readiness to change – this had been a new concept to me. The course made me feel more confident in myself as I felt I had concrete skills / techniques that I could use to move patients forward.*
> (QOT09)

For others, practice proved more challenging than anticipated.

> *I went on the first instalment of the Health Behaviour change this week. I really enjoyed it, and can see how I can incorporate the theory into everyday practice. When the presentations were being given I felt that it all made sense and that would be relatively straight forward to carry out, but when we were doing the role plays it was actually quite difficult!*
> (DPA02)

During practice exercises, many clinicians commonly experienced a shift in their professional identity with the realization that consultations could be improved. In the following extract this negative professional image shift is counterbalanced by reflection and acknowledgement of what has worked in past and what could be improved.

> *At times I thought what have I been doing up until now? Have I always told people what to do rather than eliciting change-talk from them? So it made me feel a bit deskilled in the middle of the training however an emphasis on core-conditions of empathy etc was good to remind you you have been effective in the past too*
> (QGM15)

Self-consciousness and 'clumsiness'

This reduction in self confidence remains after the workshops and for some time following the training course. Practice feels 'clunky', unnatural and intrusive and self-consciousness arises.

> *The examples on the course looked very easy + relaxed when watching experts doing the MI. the reality of trying it myself appeared initially 'clunky' and 'invasive'*
> (DPH01)

This phase of learning MI may also be anxiety provoking and frustrating.

> *I felt scared of getting it wrong, well perhaps scared is too strong a word but perhaps feeling that I would fail myself/my training and the patient if I got it wrong or felt out of my depth. I experience feelings of frustrations with myself and admitting to myself and realising that there are some patients that will leave/finish the programme and you still feel that there is still SO much input/work to be done.*
> (DNU04)

Quiet change and skill development

At first the thought of practicing MI raises negative emotion as clinicians discovered during the course how challenging it can be to practice. With practice however skill and awareness grows, and, with this, self confidence and trust in the methods increase. With time, for some clinicians months and even years, practicing MI becomes more fluid and natural. These transitions are present in questionnaires but the diary entries provide more detail and temporal dimensions.

> *Initially I had really enjoyed the theory behind the training and had hoped that I would be able to put these techniques into practice. I was apprehensive*

> *about practising them with "real" clients in case of making mistakes, getting muddled up or missing an important reflection. Practising reflecting back and trying to make insightful statements was quite difficult because at first I found myself half listening to the patient and half thinking "oh god, what am I going to say next!".*
>
> *Over time I grew in confidence and put these into place (eg numeric scale, importance and confidence, and OARS) as often as possible and now feel confident that I would be able to use them with clients, and am now not so concerned about making a mistake as these are very easily remedied.*
> (DPA02)

Here the patient and clinician are working well together and the patient benefits, this is a good example of the dancing metaphor used in MI training.

> *Discussion with patient who has work-related issues that are concerning them. Found using open-ended questions were a good way to gain an insight into the extent of these concerns, and then reflecting back what they had said seemed to be useful for the patient, who on occasion was able to see things in a more helpful way for them. They were very comfortable talking and often went off on a tangent, but I found that summarizing what I thought the key points were was a useful tool to bring them back to the present moment.*
> (DPA03)

Additionally, approximately 5 weeks after the 1st workshop, the same clinician is describing MI spirit and skills in practice. This clinician also describes later how the culture of her team was of great benefit which may have contributed to her accelerated learning.

> *Found it useful for patient to run through their "typical day" with me to get a good idea of what their diet consisted of. Goal was to lose weight by exercise and if necessary, through diet too. Found myself asking permission about the agenda and what he wanted to tackle first. Importance and confidence questions were useful too, although patient found them strange questions to*

> *be asked! Their past failures were affecting confidence so we discussed previous attempts. Realised they weren't ready to change their poor diet as didn't see it as that important, despite my attempt at giving them a little information on benefits of healthy eating (much to my frustration!). Wary that they were quite resistant in this area so made a conscious effort to acknowledge the things they were doing right. I also had to watch myself and make sure I didn't fall into the righting relax which is still tricky to do. Looking back I should maybe have asked about the pros and cons of not changing diet since they were quite resistant to do anything about it. Still find it hard to incorporate as many of strategies as appropriate.*
> (DPA03)

That practice change takes time was frequently mentioned by clinicians.

> *In the beginning of my experience of MI I didn't appreciate how powerful these skills were and how easily people could reveal details which were effecting them. Now several years down the line I recognise this much more acutely and recognise when to push further and when to back off. I feel much more aware of what I am doing.*
> (QNU02)

Moving from unconscious to conscious awareness of skills

The previous extract highlights another common theme. Several clinicians came to realize that they had been practicing MI first in an unconscious way but reflection brings insight and allows them to practice in a more aware manner.

> *Initially I used the techniques but did not realise it. This was followed by a period of time when I was able to reflect on interactions where I could have used the techniques but hadn't. I feel that I now use the techniques consciously when working with staff.*
> (QNU02)

Building trust in MI methods

The building of trust in MI methods is illustrated in the following attitude change.

> *It made me more conscious that it is the clients decision to change and appreciate the significance and importance that this desire to change comes from within the client and not the clinicians agenda. It also made me more attuned to the ethos that, just because I disagree with a health behaviour does not necessarily mean the patient wants to change it.*
> (DPA02)

As skill increases and trust in MI methods develops concerns lessen and greater insight into patients' experience is gained.

> *I am more able to allow the patient to lead the discussions and direction of sessions. I feel that I can gain a deeper understanding of how issues affect the person and their emotions.*
> (QPH17)

Even when things don't go so well the response using the reflective diary is not one of self blame. Rather a plan is made for how to proceed to help the client – this again indicates a growing confidence with the methods and an ability to use it not just in consultations but to help understand client resistance in reflection.

> *Goal-setting with VERY unresponsive patient. Extremely difficult to engage despite best efforts to build rapport prior to and during goal-setting session. We were able to set a joint agenda and explore importance and confidence in losing weight (10/10 for each) but at the same time, patient appeared very reluctant to participate. Asked them to run through their typical day routine to try to gain some kind of insight, but information given was still very limited. Need to determine whether patient is generally extremely shy and*

> *finds such one-to-one situations uncomfortable and/or there are more psychological issues going on.*
> (DPA03)

This approach works well and over the next two meetings, the clinician describes a quiet and curious approach, and the client's behaviour does indeed change – the extracts describing this illustrate well the MI methods at work and the clinician reveals a growing awareness of the process in their diary.

> *Conscious of the possibility I might increase resistance I tried to subtly introduce the idea of practicing relaxation (diaphragmatic breathing) about their daily routine. They seemed quite positive and willing to try this as long as it wasn't disrupting anything they normally did. However, although I didn't directly ask about how important it was to them, I am very interested to see if they do actually try to achieve their goal by next week, or whether it was just a case of saying they would to oblige us…*
> (DPA03)

> *The patient from last week was in fact able to achieve their relaxation goal and had found it very useful despite their initial reluctance to try something new. They were appreciating the benefits and were not resistant to continuing to practice relaxation as part of their daily routine. Now it is becoming an important thing for them to do and they are feeling confident that they can actually do this.*
> (DPA03)

Confident growth in professional identity

With skill development and an awareness of this, professional identities shift again and clinicians come to believe their professionalism has improved.

> *I honestly think it has made me a better dietitian! I seem to be able to communicate better since undertaking the training and patients definitely respond in a more favourable way because of it.*
> (QDI06)

Theme 3. Challenges and Fears

This theme captures the salient challenging aspects of learning and beginning to practice MI. These challenges raise negative emotions, are tiring, and they can result in MI strategies being avoided in favour for old habits.

> *Always thinking about using the techniques and therefore the consultations are much more brain numbing as I have to work harder*
> (QNU03)

> *It was quite tiring when first using the techniques because it required a lot of active concentration to be fully effective. At times, I was also nervous about asking questions because answers were unpredictable and often emotional.*
> (QPH17)

Old habits die hard

Trainees found that in the early days they often could not remember the strategies, tasks and skills they had been presented with during the workshops.

> *I have tried to use some of the principles but often find it difficult to remember what was advised and therefore lack confidence in trying them in practice.*
> (QDI06)

This challenging nature of practicing MI persists even, as is the case for the following trainee, at 3 years post training.

> *I need to and still do look over the information to remind myself what I am doing*
>
> *I find each time I look there is something else to try-depending on the patient group you have in at the moment.*
>
> *Some things are hard to do at first and it has taken me some time to feel comfortable using techniques i.e. scale for importance and confidence but the more you use it and when you find it helps find why things are not working, the more you try things.*
>
> *It also takes a while to know when to use a strategy but this is easier the more you do it.*
> (QPH10)

As discussed above practicing MI can initially feel unnatural and clinicians found it easy to slip back into old habits and the 'righting reflex':

> *I do think ongoing supervision would be useful as I am aware that there are still times when I feel I get stuck with individuals and am somewhat clumsy in my attempts to stay MI focused and not get into problem solving or using the "righting reflex".*
> (QNU20)

Mental Overload

Practicing MI is initially difficult and the clinician may have to multi-task while listening. The clinician can experience much cognitive activity and may have to deal with difficult feelings. The following extract illustrates this along with another common challenge, that of managing the discomfort of 'sitting with silence'.

> *I felt the time we spent was definitely not as constructive as it could have been and that I didn't reflect back enough- I think in the half an hour I spent*

> *with him it was only 3! But I did make a conscious effort in the end to summarise the main points that we had covered.*
>
> *I felt like I was missing points as I was concentrating so hard on trying to think about phrases to say and " some people say...." at the start of the sentences. I need to practice this a lot and have a clear cut idea in my head and not feel the need to rush to come out with a comment- I'm still getting used to the silent gaps during time with patients and always feel like they are waiting for me to say something whilst I'm thinking.*
> (DPA02)

Until the practice becomes more fluid and natural, this multitasking and increased cognitive activity during consultations can be challenging and tiring. One nurse described how she experienced this challenge in her diary using a metaphor of learning and needing to speak a foreign language and the resulting dissatisfaction when she gets it wrong.

> *The initial few weeks I felt exhausted using HBC as I was constantly trying to word things appropriately, it almost felt like learning a new language in a foreign country as in my head I knew what I wanted to say and ask however, wording it correctly would/could result in such a different outcome. e.g in France if you want 2 coffees but you only know how to say milk, you end up with 2 glasses of milk, so one you don't get want and two you end up very dissatisfied and still wanting coffee!.*
> (DNU04)

Directive vs non-directive clinician

Another issue often mentioned by clinicians was a difficulty in taking a directive role and structuring consultations; with many initially allowing the client to direct the consultation in a way that was not optimal. This theme was observed by and

triangulated in the responses of the Clinical Psychologist who supervised and mentored trainees after training.

> *The main issue I found early on when changing my practice was that I went too far in allowing the patient to set their own agenda. I ended up with patients going off on huge tangents and avoiding any discussion relevant to CR issues. I often had a really long chat with people which they often seemed to appreciate but I was unsure, other than being good for rapport, what the benefit was to the patient or myself.*
> (QNU13)

Concerns over sensitive disclosure

MI was described as powerful and able to facilitate client talk and disclosure. Although this could be experienced positively, for some its perceived ability to encourage sensitive client disclosure raised anxiety and fears of 'being out of one's depth'. This anxiety and discomfort may lead to avoidance of sensitive issues and could provide a barrier for practice. The following extracts illustrate both the positive and negative aspects of this attribute.

> *I remember feeling quite pleased with myself, that I was managing to get info that had previously not been touched upon. It made me feel a little nervous of the nature of the info that I was getting, but at the same time pleased that I was at least getting it!! In my previous experience the nature of the info being provided would not necessarily have even been touched upon, as it would have followed a fairly medical model. Equally I was almost dreading the response to some of my statements as I was beginning to think "I hope that the pt's response is at least straight forward and doesn't unravel another area of concern".*
> (DPH01)

> *The other situation which arose from time to time was 'opening a can of worms'.ie. Getting load and loads of info., often personal and serious issues, then feeling out of my depth as I didn't know where to start or what to say or do with the info.*
> (QNU13)

Patient characteristics and clinical contexts

Although clinicians recognized their role in the above challenges, several patient characteristics were also discussed as hindering their learning and practice. These included patient resistance, passivity, non readiness and clinical contexts which were considered less suitable for MI practice. One such context rather perplexingly was a substance misuse setting, the context in which MI was first developed.

> *Some patients make this difficult and resist strongly giving an opinion, they appear to want you to tell them how to do things and what to do.*
> (QNU13)

> *Some patients do not want to engage at all – this again is tough because it is hard to practice the techniques if you are continually met with resistance and have to back off all the time.*
> (QPH16)

> *Work with difficult client group – drug users – therefore difficult to support them to maintain changes.*
> (QGM15)

Not all clinical settings were experience as appropriate for MI practices.

> *Since I have moved away from cardiac rehab, I use the techniques less. In orthopaedic rehab, patients tend to look to professionals to be told what to do and have less influence over their own goal setting. It is more difficult to get them to change their behaviour. In cardiac, most patients appreciate that they*

might need to make changes but, for older people who might have had a fall, seem to feel less need to change their behaviour.
(QOT09)

The ward-based context of my work also affects my practice as patients do not identify my role to be that of assisting HBC and can be reluctant to discuss topics with me. Within some of the group work I do, the HBC methods have been easier to apply due to my perceived role and lengthier contact time with patients.
(QPH17)

Privacy – within ward setting, not much privacy available to discuss personal issues.
(QPH17)

Time limitations

Many clinicians reported time as a hindrance to their learning and practicing MI. This related to a perception that MI practice takes time and that consultation times limit opportunities to practice, and to a lack of time available to study and reflect on learning. Feeling time constrained was often seen as something temporary while skill is being developed.

The biggest irritant to not being able to practise this is lack of time.
(QGP04)

still find that I take longer when conducting a client interview because I am still taking time to use the techniques as I am not fluent in there use.
(QNU14)

Lack of confidence

Lack of confidence with the skills can hinder putting what is learned into practice. This is particularly problematic given that attending MI training courses may lower clinician's confidence, and there exists the risk of developing a vicious circle of lowered confidence and non practice of skills. This may explain why client feedback is so important, permitting the clinician to 'feel' the method working and benefiting both parties.

> *I think the only real problem with applying the HBC skills was my lack of confidence in my abilities, as there were times when I would want to use a technique but have backed down in case of making a mess of it. Once I got over that it was fine!*
> (DPA02)

Work environment and culture

The workplace environment may also hinder progress. The timing of the training and the time available to put learning into practice is important.

> *In terms of my workload at the time, it was not the ideal time to receive this training,*
> (QDR12)

> *Caseload size is too large making it difficult to protect time to devote sessions to MI*
> (QNU22)

These contain the implication that management and other decision makers are not facilitating learning. Lack of support from management was also more explicitly raised.

> *MI is a major feature in the area I work at the moment but I feel that leaders of this agenda are more interested in getting numbers through training rather than supporting practitioners to put the techniques into practice.*
> (QNU02)

The attitude of others, in particular colleagues who either have not been trained or who do not value MI, is also experienced as problematic.

> *It can also be difficult if colleagues do not embrace the HBC principles and still feel that the quickest way is the best.*
> (QNU14)

Theme 4. Experiential Learning

This theme captures the salient facilitators to learning and developing MI practice. These included the role plays, the course materials and handbooks, observing others, peer discussion, and the opportunity to practice with actual clients.

> *The training days, especially the role plays were very helpful. I also found it very helpful to refer back to the folder we were given and the HBC book whenever I wanted to refresh myself of the techniques. Above all, practicing the techniques with clients helped me to apply it and develop my own style of HBC It was also helpful having more experiences members of the team available to hear them give examples of how they have applied it or to ask for advice..*
> (DPA02)

Roles plays facilitate learning

Roles plays were reported as challenging but beneficial and awareness raising by over 60% of participants. The following extract illustrates this well while providing

some insight into what makes role plays difficult which for these trainees was the unnatural and artificial quality of the role plays themselves.

> *When applied in the role-plays this was difficult to do because often the scenarios were made-up, therefore quite "artificial" and unrealistic, which made me doubly conscious of what I was trying to do. I found it a lot more difficult than I thought I would. My role-play partner also found it hard, but it was a useful exercise as it really did make us both aware of our level of reflective listening. We both hoped that it would be easier and would flow better in a more naturalistic setting – i.e. with a patient. We both realised we were very tempted to want to automatically find a solution to the problem and it was hard to resist the temptation to do that – it was very easy to fall into the "righting reflex". I did discover that I felt more comfortable asking open questions as opposed to closed questions, and realised that I've probably been doing this unconsciously in my contact with patients anyway. The taped role-play was a challenge and the more I learnt throughout the day, the more I realised what I had and hadn't done and what I should have said etc. It was definitely a useful exercise as within minutes of going back into the group, right up until the end of the day, I was able to see where I'd gone wrong.*
> (DPA03)

Content, structure and feedback

The following extracts reverberate the usefulness of role plays but include other frequently mentioned facilitators including: the course materials and handbooks; observing more experienced others; peer discussions; and a theme of paramount importance, the opportunity to practice with actual clients.

> *The training days, especially the role plays were very helpful. I also found it very helpful to refer back to the folder we were given and the HBC book whenever I wanted to refresh myself of the techniques. Above all, practicing the techniques with clients helped me to apply it and develop my own style of HBC. It was also helpful having more experiences members of the team*

> *available to hear them give examples of how they have applied it or to ask for advice.*
> (DPA02)

> *The psychologist's input was great, it really consolidated what I had learned at the HBC training day. It was so good to see it for `real` in practice. The role playing during the training days was excellent, but to see it in practice was such a good learning experience. And one which I know I am very fortunate to have had.*
> (DNU04)

Access to appropriate clients and their feedback

Having access to appropriate clients is often discussed in the MI training literature as a necessary ingredient for learning MI, and this was also the case for trainees in the current study.

> *I recognise this and again think that learning from experience is extremely important, leads to deeper learning and understanding, regardless of how many times I may have read the mechanics and methodology of MI.*
> (DPH01)

Receiving feedback from clients helped trainees to recognize MI methods at work and their own skills developing.

> *Patients reactions has also had an influence, encouraging me to continue to use HBC techniques, as I have seen quite resistant patients make changes and to come to appreciate what we have been encouraging them to think about eg relaxation.*
> (QNU13)

> *I felt that the support for introducing techniques was good and felt encouraged as I started to see responses from patients when using the techniques.*
> (QPH17)

Others discuss the desire to receive client feedback which suggests its importance is recognized even when it is absent.

> *I would say that my practise has improved but it would be interesting to know how my clients found it!*
> (QNU03)

In many cases lack of opportunity to receive feedback from clients led to uncertainty about whether their intervention and style had helped. The desire to hear what clients were thinking and doing after consultations was frequently mentioned. In the following two extracts DNU05 is disappointed that she will not get to know whether her interactions with patients have helped. This is particularly important here for she described adapting MI to suit the patients' needs in an acute setting. This is Miller and Moyers' Stage 8 happening, where MI is blended with other therapeutic interventions, but DNU05 needs to close the feedback loop in order to decide if her adaptation was successful and therefore warrants repeating.

> *perhaps what I did was 'plant the seed' that may indeed change his behaviour but sadly I'll probably never know!*
> (DNU05)

> *Unfortunately I have not seen him or heard of his progress since but would be interested to know if this had an impact!*
> (DNU05)

One participant, QDI21, was identified as a deviant case. This is discussed in more detail in the following section. However for this participant, this absence of opportunity to practice with clients was described as an impediment to learning, and her disappointment relating to this is evident throughout her transcript.

> *I guess for me the lack of opportunity due to change in work practice has hampered my progress and so I would have liked to stay on track with this.*
> (QDI21)

> *As I have had few one to one clients to practice on since the training I could not say.*
> (QDI21)

> *By having more clients to practice on which would then have meant I would have looked towards supervision and used the website.*
> (QDI21)

Modelling and learning by example

The necessity of having access to appropriate clients confirms the need for trainees' work environment to support their learning and the facilitating effects of a supportive work environment is frequently discussed. This support could take the form of learning in a context in which an MI ethos has been embedded and its culture embraced, where colleagues are supportive, could be observed using the methods, and peer discussion is possible.

> *I think I have been very fortunate in the sense that the HBC methods are widely used in the service in which I was working and so I was encouraged by others and by their experiences/feed back of success stories in using the techniques. I was also keen to gain the experience of using the techniques and was supported and encouraged by my supervisors and all staff members to try them out and use them with the individual patients whom I had been allocated. These patients were selected as ideal candidates for some HBC and in that sense it helped me practice the techniques in the confidence that they had voiced a desire to tackle certain health behaviours. My work environment was consistently supportive of me using the techniques for the duration of my employment.*

(DPA02)

It helps being in the environment I'm in, and hearing the day to day language and seeing the practise of MI.
(DPH01)

The following extracts highlight the significance of observing and having the support of psychologist colleagues. This along with supervision featured frequently in narratives describing supportive work environments.

When the psychologist took over the interview she managed to diffuse things with the gentleman, (whom she agreed was a very angry and vulnerable man). She did this with reflection, in abundance, before he was accepting of what she was saying. It almost felt like reluctance on his part that he was agreeing with her. Interestingly, by the end of the interview he was a completely different man to the one that walked in initiall.
(DPH01)

My weekly meetings with the clinical psychologist to discuss complex patient is invaluable, its such a good teaching experience. Just listening to how they word a sentence and draw information and ideas leaves in me awe. I often think "why didn't I think of saying/asking that".
(DNU04)

Developing reflective practices

Participants frequently mentioned how their reflective skills develop as they learn MI. There appears to be a reciprocal relationship between reflection and skill development; with reflection encouraging the development and consolidation of MI skills, while these in turn appeared to lead to continuing and deepening reflection. How reflection developed and facilitated learning was evident, particularly in the reflective diaries in which the content of reflection was more detailed and apparent. Reflection facilitates learning by allowing the trainees to recognize and contemplate

both MI adherent and MI non-adherent characteristics of their interactions with clients. This in turn leads to learning; to action plans; and to praise, positive encouragement and reinforcement even when things could have gone better and MI non-adherent practice is recognized.

In the following extract an action plan is made even when MI adherent behaviour is acknowledged.

> *She seemed relieved when we spoke about it, and I felt that I used active listening and empathy to normalise it for her.*
>
> *Overall I felt that as a whole the time went well. I was trying to reflect back her points and not put words in her mouth- trying to illicit ideas of how she could help her mood.*
>
> *Action: I think I need to read over the HBC articles again and practice the importance and confidence technique. I also would like to sit in with more assessments by the psychologists to see it in practice and will ask my supervisor if this would be possible*
> (DPA02)

In contrast the following extract describes a less satisfying consultation and the learning that results from reflecting on this.

> *I am disappointed with the amount of reflecting I did. I think sometimes I'm so busy concentrating, as it's not yet a habit for me I keep forgetting. I was also aware of giving him the answers more than perhaps I should have. I was trying to elicit answers from him but he so often says I don't know I felt I had to give him some help. I'm also not yet in the habit of speaking in a certain way e.g. 'asking permission' and 'being curious' which are also elements I need to work on. I think perhaps because my last session went so well that I presumed this one would too.*
> (DNU05)

Here the participant reflects on her experience of observing a psychology colleague and in so doing gains insight into MI in practice and becomes aware of what needs to be done in order to develop MI skills.

> *Again, it was an excellent experience being present whilst the psychologist was leading the discussion, and observing her HBC skills and motivational interviewing. This I can only learn from and take with me. I could see with the correct technique and not jumping in with solutions that the patient came up with the problems and solutions himself, we just guided and supported him with careful wording. So, the most important skill that I have learned is to first and foremost listen to the patient and allow them to set the agenda (as they always have one), be patient and don't jump in with answers and solutions which is what I want to do automatically, its ingrained in me….*
> (DNU04)

Additionally it appears that the experience of learning MI encourages continuing reflective practice.

> *My approach to assessing patients, doing goalsetting and other patient related activities has changed – this has taken time to evolve and I am continuing to reflect on this on a week to week basis.*
> (QPH16)

> *Am much more reflective, I review interactions critically to illicit what I could have done to improve the outcome. I tend to watch people more closely and analyse their behaviours.*
> (QNU02)

Although it is not explicitly stated, having experienced supervision may have developed the following clinician's ongoing reflective abilities and hence their reflective practice

> *The other important asset was the ability to have supervision with an experienced mentor. I have found this even more valuable now after practising the techniques over a period of time. The discussions I now have are much deeper than previously and have stimulated my thoughts/feelings on my abilities to use MI.*
> (QNU02)

Reflective practice can be seen as necessary, even after 3 years in the case of QPH10. Reflection can be facilitated by taping consultations and reviewing these either with a colleague or peer, a supervisor or on one's own as is the case in the extract from QPH10 below

> *Feel that I will always be learning but I need to keep reviewing what I do- for part of my job I have to record sessions and I find it really helpful listening back on what I have said and reflecting on what was good or what could have been better.*
> (QPH10)

The participants who completed reflective diaries experienced benefits from keeping a reflective diary and reflection more generally. This was explicitly articulated along with acknowledging having benefited from participation in this study as it encouraged reflection.

> *I would say doing the study has been a positive thing because I've really had to reflect on my practice (more than I would normally) and figure out where I could improve, what I need to remember to do the next time etc. I think doing the diary and writing things down is useful as it gets you into the mindset of reflecting on your work and can help you find solutions - you are actively taking time out to think about how you go about your job, and you can sometimes discover things you wouldn't necessarily have discovered had you not written it down in a diary format.*
> (DPA03)

Follow up training and support

Many clinicians stated that that they benefited (or would have had it been available) from on going support in the form of follow up workshops, case discussion and supervision.

> *Also development days and meetings ie. opportunities to discuss our patients with other multidisciplinary members is useful. This has aided my learning and reinforced the ethos.*
> (QNU13)

This need for further training was confirmed by the Clinical Psychologist who mentored trainees and who observed that clinicians were not being directive enough and offered further training to remedy this.

> *In terms of specific HBC techniques early observation showed that many staff new the approach become too "non-directive" in terms of following patients first suggestions and letting patients talk freely on any subject. There was little structure to the 10 minutes available in goal setting session. After discussion with staff, top up training was offered looking at the balance between directive and non directive work in HBC*
> (QPS03)

Theme 5. Personal and Professional Gains

This theme describes the beneficial attributes that participants perceived MI to have and to deliver.

> *Where it 'worked' it seemed to do so profoundly, which makes dealing with patients much more satisfying*
> (QGP04)

Benefits clinicians and clients

MI was described by the majority of participants in ways that suggested clinicians recognized how the methods made their job easier and benefited both themselves and their clients - particularly those clients who are resistant to change.

> *I have found it a very useful tool, especially when faced with difficult patients who are initially unwilling/resistant to change. I find you can discover more about a patient, their lifestyle and their motivations by using HBC methods and this can give you more information to work with.*
> (DPA03)

> *However, even a short time using these skills gains me better insight into patients needs and seems to be more effective in promoting HBC than previous communication approaches.*
> (QPH17)

In the following segments the negative experiences arising when a client resists or doesn't change, appear to be experienced less often. They also suggest clinicians are adopting a style of allowing client to take responsibility - another tenet of MI.

> *Makes me less personalise what happens in a session or if things have not worked out as should be THEIR GOAL/PLAN not mine.*
> (QPH10)

> *much calmer- don't feel defensive now when people are being confrontational, argumentative*
> (DPH01)

Applicability and flexibility

In the following, MI is perceived as particularly useful in a substance misuse setting preventing the consultation becoming encumbered by client issues as had been her earlier experience.

> *Since using MI in sessions with my clients I am more likely to be led by the client and try to go with any resistance. I have been able to work with the ambivalence that the majority of clients have with regard to their substance misuse in a more effective way. I get the impression that clients are more likely to feel 'heard' in sessions and that this has a positive impact on developing a therapeutic relationship. For individuals with difficult life experiences, MI provides a way of focusing on the here and now problems and I think this can be helpful as previously I had a tendency to get 'bogged down' by the myriad of issues that clients present with.*
> (QPS07)

This clinician also reported benefits over CBT in this setting.

> *I feel much more confident in using the skills to work with resistance and ambivalence than I did previously as these are not areas which are easily addressed by cognitive behaviour therapy*
> (QPS07)

The MI consultation style was also seen as beneficial in rehabilitation settings.

> *I now work less in an acute setting and more in Phase III. It is easier to leave the 'traditional' nurse role behind. I feel more of a rehab. focus which is reflected in less info. giving and more use of HBC approaches in my every day practice.*
> (QNU13)

MI skills were also described as being useful more generically. Other clinical settings where they were useful were described including psychosis, oncology and smoking cessation. In particular many clinicians found the skills beneficial in their personal lives.

> *Yes I have more consciously used motivational techniques when working with two of my young people with psychosis. I found the conversation opened up considerably and communication did become slightly more relaxed and comfortable.*
> (QNU20)

> *Since I finished the HBC course I have worked in acute stroke and now in oncology as a rotational physio post. Both still very relevant to HBC methods. Have had he chance to use them in relation to stopping smoking & exercise post-surgery in cancer.*
> (QPH17)

> *I finished the course much more aware of the techniques and have now begun to consciously use them not only in work time but in home time*
> (QNU02)

As already discussed the time it took to practice MI was often described as an issue. Often it was described as taking longer and leading to frustration. However as skill develops clinicians come to recognize that even short consultations could be insightful, could benefit clients and could bring about change.

> *Time is still an issue and I'm not sure how this can be overcome within my setting. However, even a short time using these skills gains me better insight into patients needs and seems to be more effective in promoting HBC than previous communication approaches.*
> QPH17)

Cultural change

MI was described as encouraging teamwork and was perceived as bringing about cultural change in clinicians' perceived models of clinical care.

> *Work interactions have also changed as I feel we work more as a team now. Although multidisciplinary team members bring different areas of expertise our goal setting time and feedback with patients follows the same rational and style.*
> (QNU13)

The theme in the last extract of benefits arising from colleagues sharing a common style was echoed in other extracts which suggested having colleagues attending the training was useful. A related concern raised was that over time without continuing training these benefits would be lost due to skill depletion and due to untrained colleagues joining teams.

> *Getting so many of my colleagues on the training has made team discussions easier. When I first arrived I occasionally questioned their hurry to move to an action phase (I don't think they understood this language and I wasn't very good at explaining it). Now we're all versed in MI and the cycle of change and I feel better understood.*
> (QNU20)

> *Updates every few years would be useful. People may slip back to old ways.*

> *Future training issues. It is difficult to assist new members of the team to appreciate HBC techniques and explain an intensive 2 day course by shadowing members of the multidisciplinary team members and seeing HBC in practice.*

> *As numbers of new members grow, who have not attended the training, this could have an impact on the effectiveness of our team. If we are not all following the same ideals then something could be lost.*
> (QNU13)

4.2 Findings from deviant case analysis

One participant's text differed in content and mood from the others. There were stronger negative emotions, concerns about the workload that the course and learning MI might entail, and frequent expressions of disappointment and self-blame that learning MI had not occurred as had been expected. Additionally in contrast to other participants who despite having experienced challenges and negative emotions, go on to describe MI skill development, this was not evident from the deviant case. Although this deviant case contrasts with other clinicians' experiences, examining the case closely, revealed potential hypotheses and explanatory models for this contrasting experience and support for much of the findings described above. It illustrates what may happen when appropriate opportunity to practice and reflect is not available. Unlike other participants she appeared to be working in isolation of other trainees and her case additionally highlights the benefits of being part of and learning with a team, and of the facilitating and supportive effects of interactions and observations with peers and mentors. In so doing it triangulates and strengthens the validity of the findings already discussed relating to how practice with actual clients, supervision and reflection facilitate and consolidate learning.

The findings relating to this deviant case are outlined in more detail in Appendix 4.2.

4.3 Contrasts between the questionnaires and diary data

While many of the themes found in the diary data matched those of the questionnaires thus triangulating the findings (Yardley, 2008, p. 240), some contrasts between the questionnaire and diary data were also evident.

The diary data provided more detail, and as expected, temporal dynamics. This additional detail shed light on process information. For instance in questionnaires participants reported that reflection facilitated their learning. In the diaries however

the finer detail provides insight into the facilitating effects of reflection and of keeping reflective diaries in particular. Additionally the temporal perspectives provide detail of change over time.

A further contrast was that the questionnaire data was richer in proportion to the word count. Hence, proportionally the number of themes found was substantially higher in the questionnaires. This was due partly to the detail of the diary data but also because not all diary data was relevant to the experience of learning MI. For instance one entire diary instalment contained nothing in relation to learning MI. It contained rather reflections about concerns over how best to utilize supervision, and though not uninformative this was not directly relevant to the aims of the study and was therefore not coded during the analysis phase.

The questionnaire data was also extremely dense and many paragraphs often contained several salient themes. This may be due to the fact that participants were able to choose when to write their responses, choosing perhaps extremely suitable times, and to take time to reflect, and to edit their responses in ways that made them concise and meaningful. This makes the open-ended questionnaire method extremely valuable for data collection where computer literate, motivated professionals are being investigated, and the study design is planned and executed in such a way as to maximize their potential.

Chapter 5 Discussion

Contents

5.1 Partial and contextual nature of findings

Humans, and therefore respondents and researchers alike, are indelibly 'persons-in-context', and any account of research findings is necessarily derived and co-constructed by respondents and researcher, their relationship and their world (Larkin et al, 2006). Due to the contextual nature of the research process itself, the findings reported here are inevitably only partial depictions of the experience of learning MI. This partial nature is founded in:

- the sample chosen by the researcher,
- the choice of participants to participate or not,
- the courses they attended,
- their social environments,
- the questions asked and how they were asked,
- what the participants chose to disclose, and
- fundamentally in the interpretation made of these disclosures by the researcher.

One might question therefore whether there is a more or a less emotional and eventful experience of such training programmes out there that has yet to be identified and heard.

This study therefore makes no claims to the generalizibility of its findings. Nevertheless it is useful in providing some insights into how learning MI is experienced by multi-disciplinary health professionals, and some tentative recommendations can be made on this basis. Not all participants articulated all the themes identified, therefore the findings must be interpreted as a set of potential experiences that may be relevant to other health professionals learning MI. It should however be borne in mind that the similarity in the experience of multiple disciplines across two health contexts and two training programmes in Scotland suggests commonality in experience.

Figure P.1 above provides a diagrammatic representation of the experiences and processes that may arise when learning MI as suggested by the current study's findings.

5.2 Comparisons and extensions of existing MI training literature

The training courses followed by the participants of this study were representative of many of the studies found by Madson et al (2009) and comprised all the salient attributes of these including their duration, content, and format. In this sense they can be thought of as intensive but typical MI training packages, combining didactic instruction and experiential activities. The substance misuse training programme taught MI Phase 2 skills, in particular Stage 6 (developing a plan for change). None of the studies included in Madson et al's review described addressing Phase 2 aspects of MI in their courses. While they acknowledge that journal space limitations may explain why, it should nevertheless be heeded that the experiences of several of participants in the current study resulted from what Madson et al suggest are "more inclusive" (p.104) training programs.

The study has found much overlap with existing MI training literature. This form of triangulation adds credence to the findings of the current study. Additionally these findings, obtained via original qualitative methods, corroborate and strengthen the existing knowledge in relation to how clinicians experience learning MI. Previously undocumented findings such as the emotional experiences and the shifts in professional identity have also extended and enhanced this understanding further.

The study has attempted to avoid the shortcomings listed by Madson el at (2009) in their systematic review of MI training. Specifically:

- the training programmes from which participants were recruited included ongoing supervision and coaching as recommended by the extant MI training literature;
- the aims and content of training programmes themselves have been described in detail to contextualize the findings and to increase external validity;

- the participants were recruited either immediately or up to three years post training workshops, therefore a diverge range of potential experiences was captured and informs about the experience of learning MI in the longer term; and,
- although subjective, participants' impressions of client outcomes were captured and described.

In addition Madson et al (2009) recommend that future MI training research should explore training outcome constructs such as trainees' feelings of confidence and self-efficacy, intention to use MI and their attitudes towards and knowledge of MI. The current study has fulfilled these requirements. Of crucial importance here, is that this exploration has revealed that a reduction in confidence might be a valid post workshop outcome. Relevant here too is that eventual training outcomes may not be available or measurable until sometime after initial training.

5.3 Four Stages of Competence Model

The findings can contribute to this model of adult learning which is often referred to in mentoring and training literature, and whose origin is uncertain. The model asserts that learners pass through four states of consciousness and competence when learning a skill (Howel, 1982; Flower, 1999). The four stages are:

1. *Unconscious incompetence* which occurs when an individual is unaware that they don't know something and has no motivation to address this deficit;
2. *Conscious incompetence* occurs when an individual learner knows they don't know something. Thus the individual is aware that a lack in knowledge, skill and ability exists;
3. *Conscious competence* occurs when a learner knows how to do something but demonstrating the skill or knowledge requires consciousness effort or concentration; and

4. *Unconscious competence* which occurs when an individual has practiced a skill extensively and it has become 'second nature' and the knowledge, skill and ability can be demonstrated without conscious awareness or concentration.

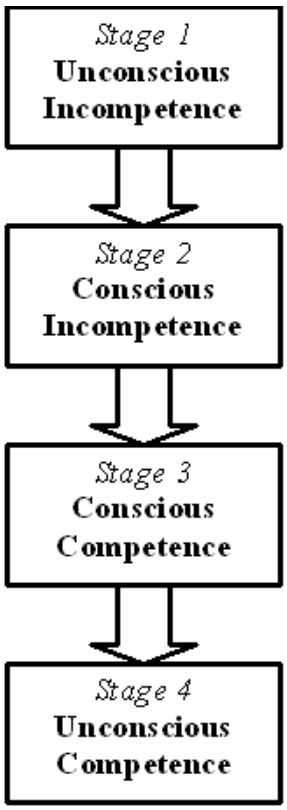


Figure 5.1 Four stages of Competency Model of adult learning

A fifth stage of this model has been posited which is less accepted and more controversial. This stage has been referred to as 'conscious competence of unconscious competence' which arises when someone is able to "recognise and develop unconscious incompetence in others" (Bradford VTS Online Educational Resources, 2009, p. 4)

This model is evident in the current study. Being invited to the training and beginning to observe and take part in role plays moves trainees from unconscious incompetence to conscious incompetence (sub-theme *Fragility and vulnerability of professional identity*, p.78). Not apparent from the extant literature and in evidence in the current study is that conscious incompetence may be accompanied by shifts in

professional identity and often strong negative emotional experiences during and outside consultations (sub-themes *Professional identity and confidence fluctuations*, p.78; and *Disappointment, disillusionment, lowered mood*, p.76). As competence grows confidence increases but this can also be a tiring phase in learning MI (sub-themes *Quiet change and skill development*, p.80; and *Mental Overload*, p.86).

Also not evident from the extant literature is the suggestion that as clinicians become more practiced in MI, and through reflective practices, an awareness may arise of skills that they have been using unconsciously (sub-theme *Moving from unconscious to conscious awareness of skills*, p.82). This is not the same as the fifth stage described above and represents a shift from stage four (unconscious competence) back to stage three (conscious competence). This backward shift is not apparent in the literature on this model nor in learning MI, and it may actually be desirable for skills involved in therapeutic interventions where an awareness of what one is saying and doing is necessary. This is particularly relevant in full-blown MI where according to Rollnick et al (2002), "the principle difference between BCC and MI, then, is the practitioner's conscious and strategic use of his or her own responses to elicit and reinforce certain kinds of speech from the client, while reducing other types of client responses" (p. 279). This implication that stages 3 and 4 may actually be juxtaposed for some adult learning, should be explored in further research.

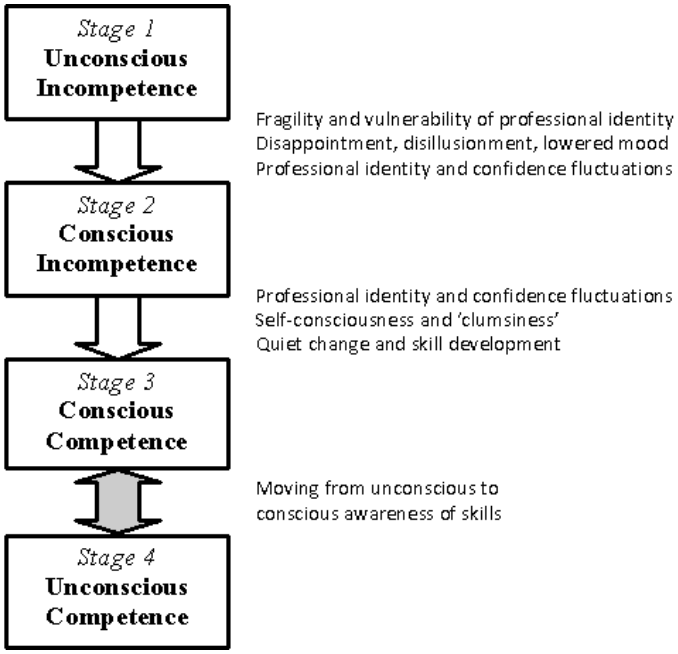


Figure 5.2 Revised Four stages of Competency Model showing relevant themes

5.4 Managing the challenging experience of Learning MI

As has been discussed learning MI may provoke anxiety, modify professional identities and reduced confidence. This is entirely in line with Miller and Mount (2001) who claim that new practices feel awkward initially, and that implementing them may at first diminish therapist congruence.

Rollnick et al (2008, p.177) suggest that MI should be thought of "as a complex clinical skill that is developed and refined over the course of one's career". While it cannot confirm that refinement of MI skills spans entire careers, the study has produced plentiful evidence that learning MI is challenging for health professional even three years post training (sub-theme *Old habits die hard*, p.85).

This has implications for trainers and their training courses. To promote attendance and engagement with training, it might be beneficial to set realistic expectations in an effort to normalise this experience and to minimize the impact of the compromised professional identity and negative emotions that might be experienced while learning MI. Prospective trainees could be informed about this in pre-course literature or early

in training. Additionally, the inclusion of many of the benefits that were experienced in the longer term might be helpful. These benefits include – increased feelings of professionalism, improved client outcome, improved team work, and decreased stress and feelings of responsibility (sub-themes *Confident growth in professional identity*, p.84; *Benefits clinicians and clients*, p.102; and *Cultural change*, p.105). Non provision of workplace and follow-up support in line with trainees' needs, creates a risk of leaving trainees feeling deskilled. If this remains unremedied there exists a risk that demotivation will arise, and with this, the potential of decreased work satisfaction and increased staff turnover.

The MI approach contrasts fundamentally with the authoritarian expert approach of the traditional medical model that health professionals and nurses in particular have been socialized to. In line with nurses' experiences in Söderlund et al's (2008) study the clinicians in the current study often found they reverted to old habits of more traditional expert advice giving modes of communication and interaction. In particular, clinicians found it difficult to overcome the 'righting reflex' which arises when clinicians argue for and advocate change (Miller & Rollnick, 2002), and which can be counter-productive in discussions about health behaviour change (sub-theme *Old habits die hard*, p.85). Further, the trainees reporting of the challenges to their learning MI posed by patient resistance and passivity and their unwillingness to accept responsibility for their health, also echoes the experiences of Söderlund et al's nurse population (sub-theme *Patient characteristics and clinical contexts*, p.89). This triangulation of findings in unrelated studies and populations provides credence for the findings of each study. Both studies suggest a major challenge in learning MI is the new way of thinking and behaving required when practicing MI.

These findings show that barriers to learning MI include resistant patients, and those with low self-efficacy and apparent reliance on being told by a practitioner what is required of them. This, and the fact that not all clinical contexts were found to be consonant to the MI approach (sub-theme *Patient characteristics and clinical contexts*, p.89) highlights that an MI approach may not suit all patients in all contexts and reliance on the authoritarian and other approaches may on occasion be advised.

This is seen as a barrier by MI learners but the models of health behaviour summarized by Ogden (2007) could shed light on this and facilitate understanding and the development of skills to manage it.

In their attempt to construct a theory of MI, Miller and Rose (2009) emphasize two active components: a relational component based on empathic understanding and the MI spirit, and a technical component which emphasizes evoking and reinforcing change talk. It would however appear that other concepts such as locus of control, self efficacy, health and illness beliefs, social environment and resources, which have been researched and theorized using the models of health behaviour (Ogden, 2007) could also explain some of the active ingredients of MI. For instance it is likely that these concepts are being discussed and explored in interactions attempting to resolve ambivalence with patients. If this is the case then these models which have indicated differential influences of these concepts within different illness contexts could inform how MI can best be utilized within these contexts. This information could then be imparted during training and facilitate improved patient outcomes.

Britt et al (2004) suggested exactly this and noted that models of health behaviour had in common with MI, three constructs: patients' expectations about the potential consequences of their behaviour; the influence of their beliefs about their personal control over their behaviour; and the social context of their behaviour. Britt et al also stated that the processes and key elements of MI should be understood. Specifically they suggested that how best to respond to resistance, which patients benefit most from which aspects of MI, and how a patient's level of motivation and other characteristics may influence the effectiveness of MI should be specified. This challenge remains outstanding, and Miller and Rose's theory barely begins to address them.

Finally, Rollnick et al (2008) describe 'road blocks' which are practitioner utterances that disrupt the patients flow, and may take them in another direction losing potentially crucial information and reflection. They advise trainees first to recognize these road blocks as they come to mind and avoid saying them, but secondly learn to silence their 'inner chatter' in order to fully attend to what the patient is saying,

instead of thinking ahead. This inner chatter relates to patient issues but the current findings also highlight that in the early phases of learning MI trainees have 'inner chatter' relating to their MI practice and what they should be saying next. This is quite different from what Rollnick et al describe but is none the less relevant. This can be disruptive and tiring for the practitioner but it diminishes with time and practice (sub-themes *Mental Overload*, p.86; and *Quiet change and skill development*, p.80).

5.5 Professional Identity

Smith, 2004 (p. 49) suggest that "identity in all its guises, manifestations and complexities" usually appears as a key organizing construct in qualitative research and he asks why identity has played a marginal role in psychology. Shifting professional identities have been shown here to be central to the experiences of the health professionals learning MI, leading at first to a negative emotional experience, and reduced confidence, then with time, reflection and practice, to an increased sense of professional identity and confidence (Theme 2. Professional Identity Shifts, p.77). Shifting identities may not be foremost in trainers and trainees minds when teaching and learning MI, and the focus is more usually knowledge and skill building. Clinicians experienced this shifting identity mostly unexpectedly, hence the resulting negative emotions. Perhaps this experience could be made more transparent and normalized during training. Specifically, shifting identities should be heeded by trainers, and trainees explicitly informed to expect such shifts in identity and how best to negotiate these transitions through practice and reflection.

While the effectiveness of CBT training programs is under researched (Haarhoff, Gibson, & Flett, 2011), as is the measurement and routine monitoring of therapist competence and adherence in its delivery (Davidson & Scott, 2009), models of how therapists learn CBT, and what methods and training processes best facilitate this have begun to be developed. The current findings suggest that learning MI has much in common with learning CBT.

For instance, that learning CBT is stressful and is accompanied by self-doubt has been documented (Bennett-Levy & Beedie, 2007). Bennett-Levy and Beedie investigated what happens to self-perception of competence (SPC) during a 1 year CBT training programme. From their qualitative data Bennett-Levy and Beedie developed a model suggesting the primary influences on SPC were: new learning opportunities (acquiring knowledge, implementing knowledge, external evaluation, experiences with clients); self-reflection on skills and performance; increased awareness of the standards required for CBT therapists; and emotional state (in particular emotionally salient memories and current stress levels). Also in line with the recommendations made in the current study, in order to reduce stress and normalise experiences, Bennett-Levy and Beedie recommend informing trainees about the potential fluctuations in SPC.

The Declarative-Procedural-Reflective (DPR) model has been developed to conceptualise skill development in CBT therapists (Bennet-Levy, 2006, Bennett-Levy, Thwaites, Chaddock & Davis, 2009; Kuyken, Padesky & Dudley, 2009). The DPR model describes three information processing systems - the declarative, procedural and reflective systems. Bennett-Levy, McManus, Westling, and Fennell (2009) have explored which training methods and practices (e.g. reading, lectures/talks, role plays, modelling, and reflection) best enhanced the development of these systems, and hence trainees' CBT knowledge and skill.

Much of these findings are consistent with the findings of the current study and understanding the experience and processes of learning MI may be progressed by utilising these models developed for CBT. Future research should explore this possibility.

5.6 The need for reflection, supervision, mentoring and support

Participants frequently mentioned how their reflective skills develop as they learn MI (sub-theme *Developing reflective practices*, p.97). There appears to be a reciprocal relationship between reflection and skill development; with reflection encouraging the development and consolidation of MI skills, while these in turn appeared to lead

to continuing and deepening reflection. How reflection developed and facilitated learning was particularly evident in the reflective diaries in which the content of reflection was more detailed and apparent. Reflection facilitates learning by allowing the trainees to recognize and contemplate both MI adherent and MI non-adherent characteristics of their interactions with clients. This in turn leads to learning; to action plans; and to praise, positive encouragement and reinforcement even when things could have gone better and MI non adherent practice is recognized.

Clinical supervision and mentoring have been found to be necessary components of MI training. Done well these relationships can facilitate reflection and reflective practices in trainees (sub-themes *Modelling and learning by example*, p.96; and *Follow up training and support*, p.101). Using Vygotskian and related theory and constructs, supervision and mentoring can be viewed as methods of providing scaffolding to support trainees as they develop skill within their personal ZPD. The form that such scaffolding takes will be varied and should be modified to accommodate clinicians' existing professional roles, background and disciplines, and, the skills, knowledge and experiences they bring to the learning situations. This highlights the need for trainers and supervisors to be flexible in how they approach different trainee groups and training contexts.

Educationalists have explored Vygotsky's theory in relation to adult learning. Through their work with teachers who taught adult learners, Tinsley and Lebak (2009) have defined a construct known as the 'zone of reflective capacity'. This construct shares theoretical attributes with the ZPD and describes how an adult's capacity for reflection can be expanded through collaborative interaction over an extended period of time with other adults with similar goals. The current study has produced evidence that supervisory relationships, and group and peer supervision facilitate developing skill and reflective abilities. It has however also produced evidence that completing reflective diaries may also produce a similar result (sub-theme *Developing reflective practices*, p.97). Vygotsky's theory essentially emphasizes the social construction of knowledge and skill, however keeping reflective diaries, an essentially introspective activity done in the absence of any

social interaction, may also support adults in developing and expanding their 'zone of reflective capacity'.

Some participants reported not being offered and/or not utilising supervision, then went on to describe supervision experiences in their open-ended questionnaire responses. This suggests that there may exist a discrepancy in terminology between professions. Not all disciplines may understand supervision in the way that psychologists and indeed MI trainers might, and some disciplines may liken it more to managerial supervisory relationships. For instance some professions may understand supervision in terms of accountability and management. It is therefore important that the benefits of supervision and what it entails are explicitly explained to trainees to encourage uptake of the types of support that are necessary to learn MI.

Miller et al (2006, p. 31) suggest that "an onsite mentor" facilitates the acquisition of the specific skills of a new treatment and increases persistence in behaviour change endeavours. They add that without ongoing onsite reinforcement and support, practice may revert back to prior habits (sub-theme *Old habits die hard*, p.85). This is evidenced in the current study and the difficulty of slipping into old habits was frequently expressed by respondents. The utility of supervision, mentors and support was also recognized, particularly by those who completed the cardiac training programme and who did receive on-site mentoring and support. Some support was also provided via the telephone and it was not possible to establish whether on site supervision was more effective. The experiences of the deviant case also highlight the problems that may arise if supervision and other support is either not provided or not utilized.

Another issue often mentioned by clinicians was a difficulty in taking a directive role and structuring consultations, with many initially allowing the client to direct the consultation in a way that was not optimal. This theme was observed by and triangulated in the responses of the Clinical Psychologist who supervised and mentored trainees after training (sub-theme *Directive vs non-directive clinician*, p.87). Rollnick et al (2008) recommend a 'guiding style' where clinicians direct the consultation, but allow the patient to voice why and how he or she might change. It is

evident from the findings that without guidance from a coach or supervisor, clinicians tended in the early stages to become overly non-directive and allowed the patient to take the lead. Essentially they too readily shifted to a 'following style' and although this and a 'directing style' are legitimate in MI, Rollnick et al posit that problems may arise when the use of these styles is incongruent with the task in hand. This issue was remedied via the group supervision as evident in the trainees' transcripts, and this is something that coaches and supervisors should be alert to with trainees in the early stages of MI practice.

Many participant responses suggested that MI practice and skills were not always recognized and were often mistakenly attributed as non-adherent to MI. As well as addressing behaviours which are MI non-adherent, supervision requires to address this type of ambiguity. With supervision, misconceptions that trainees are contravening the MI spirit and methods can be realigned, and their confidence enhanced. When non-adherent tactics are being utilized then receiving appropriate feedback will bring this to the clinician's attention. In both cases learning and improved MI understanding and skill should result.

Clinicians in this study report concerns relating to sensitive disclosure which can result in clinicians avoiding utilising the MI spirit and sensitive topics (sub-theme *Concerns over sensitive disclosure*, p.88). It is known that patients describe the desire to disclose issues such as abuse, and opportunities to do so being blocked or ignored by clinicians (Nelson & Hampson, 2005). Being asked about abuse can be crucial and even a prerequisite in building rapport, and not being asked or able to disclose this information may cause distress and anger (Read, Hammersley, & Rudegeair, 2007). This is problematic as low mood, health behaviour and health beliefs may be underpinned by past experience, and if these important topics are not explored then behaviour change may be compromised. For this situation to be remedied and in order for clinicians to become more confident in MI consultations, it is recommended that some training on asking about sensitive issues and managing sensitive disclosure be included in MI training programmes. Onward referral

pathways and emotional support also need to be made explicit and available if trainees are to fully embrace the MI approach.

5.7 Eight stages of learning MI

Phase 2 MI skills (developing change plans and transitioning and blending) are evident in the current study even although they were not specifically taught in the cardiac training programme. Stage 8 which requires transition and blending of other therapeutic models was particularly evident (sub-theme *Access to appropriate clients and their feedback*, p.94). Several trainees appear to have recognised the need for utilising other approaches depending on client issues. Problematically though, not all participants recognized the relevance of being able to blend other styles and felt that when they did they were violating the MI approach. Since integrating MI with other approaches leads to synergistic benefits (Miller and Moyers, 2006; Miller and Rose, 2009), it may be advisable to explain the eight stages to trainees so that they are at least aware of them and of the fact that other therapeutic techniques can effectively be incorporated into MI consultations.

Although some evidence from the current study suggests it is not, if future research confirms that the trajectory of learning the skills for each stage is linear, then it should not be expected that trainees will be competent in the later stages following initial workshops and learning outcomes should reflect this. In this eventuality, follow up and booster training sessions, supervision, mentoring and other support mechanisms will require to address Phase 2 skills training.

5.8 Learning from clients

Having access to appropriate clients is often discussed in the MI training literature as a necessary ingredient for learning MI, and this was also the case for trainees in the current study (sub-theme *Access to appropriate clients and their feedback*, p.94). Rollnick et al (2008) and Miller and Rollnick (2002) propose that training should

focus on learning from clients rather than aiming to build skill and competence in a workshop. That clinicians learn from interactions with clients is confirmed by the current findings. Additionally clinicians have awareness that they need such feedback and desire it when it is not available. Also confirmed is the necessity of practice with *real* clients (in contrast to simulated clients) to promote learning MI (sub-theme *Content, structure and feedback*, p.93). Rollnick et al describe how the process of learning from clients may work in practise. They explain how through listening to clients' own speech one gets immediate feedback about how well one is doing in a consultation and in learning MI. It is suggested that initially this can be difficult to hear in the midst of consultations and that recording and listening to them retrospectively may facilitate this.

This process and the benefits of recording sessions are confirmed by much of the participants' responses in relation to how they experience being with clients and the feedback this provided them (sub-theme *Developing reflective practices*, p.97). In the deviant case, essentially appropriate feedback has not been received. This case highlights that even when trainees are enthusiastic about MI and see its relevance to their practice, without access to appropriate clients and reflective practices their learning may be curtailed and negative consequences may result. This experience further illustrates the importance of having timely access to appropriate clients. It further backs up Rollnick et al's theory and suggests that not only do clients facilitate this learning, they may in fact be necessary for learning to occur.

In contrast to the deviant case as evidenced by the majority of participants' reported successful skill development, it is recommended that soon after training courses, work environments make appropriate clients available and support trainees by making available protected time, supervision and other reflective learning opportunities.

5.9 Culture Change

It is evident from participants' responses that in the Cardiac Rehabilitation setting culture change had occurred over the course of the three year training programme (sub-theme *Cultural change*, p.105). When this occurs it should be considered that the experience for those more recently trained may be different from those trained in the earlier stages. This contrast might arise due to training programmes evolving, due to more staff working in clinical settings who have been exposed to MI, and due to MI having been incorporated into routine practice. This culture can be helpful but also threatening to unskilled clinicians if it is not managed appropriately.

Further the findings here suggest that consideration should be given to new staff entering settings where MI practice has become embedded. Joining such teams may result in clinicians feeling deskilled and vulnerable, while existing skilled staff may become concerned over the dilution of MI practise and the challenges that this raises for them (sub-themes *Work environment and culture*, p.91; and *Cultural change*, p.105).

Future training and research should explore whether cultural change theories have a contribution to make in MI dissemination practices.

5.10 Increasing participation in training programmes

Participants reported that MI practices benefited clinicians and clients alike. When the skills are working well the clinician's job can be made easier and more satisfying Improved teamwork was described as a benefit of entire teams being trained and utilising the approach. MI was reported to facilitate handling resistant patients, and to enable rapport building and information gathering which is useful in finding ways to work with clients. Many clinicians reported being better able to work with more sensitive issues. They also reported feeling less need to defend against confrontational patients, and feeling frustrated and responsible for patients who do not change. Clinicians also find benefits in their personal lives. Resistant patients

appear relieved and good outcomes in lifestyle changes are observed (sub-themes *Building trust in MI methods*, p.83; *Access to appropriate clients and their feedback*, p.94; *Benefits clinicians and clients*, p.102; *Applicability and flexibility*, p.103; and *Cultural change*, p.105). All of this suggests that clinician work place stress and perhaps burnout may be reduced as a result of learning MI and this could be explored in future research.

Lieb (1991) suggests that interest and selfish benefit are the best motivators for adult learners. Race (2005) suggests that motivation to learn may be enhanced by attempting to increase the perception in learners of their 'need' to learn through convincing them of the benefits they may achieve when they have put in some effort to achieve the learning. In an attempt to increase participation and engagement with MI training programmes in future, some of the benefits discussed above could be provided in pre-training literature. These might include informing potential trainees of what they will be able to do when they have learned the skills, the benefits of this for client outcomes and their own professional identity and competency, and the additional potential of their jobs being made easier and consultations less stressful. Additionally heeding Race's model and approach it may also be useful to remind all learners of such benefits throughout and in particular at the end of training courses in an attempt to encourage active practice, to make the most of feedback from clients, peers and their own observations, and to use this to digest and make sense of the knowledge they gather – all processes central in Race's Ripples model for optimizing adult learning

5.11 Written data collection methods

Issues have been raised relating to the difference between oral and written communication. Oral communication has been described as less abstract and closer to the individual's experience, and written communication as more abstract and objective. Mann and Stewart (2000, p. 193) suggest that "participants who are committed to expressing their opinions or sharing experiences usually aspire to communicate detailed information with clarity and conviction". To this end Hamilton

and Bowers question “whether the interview is accomplished orally or in writing might have less impact than the overall commitment of the participant to the questions being investigated in the research” (p. 829). The quantity and quality of the responses in the current study substantiate both these claims, and the use of E-mail distribution and electronic completion methods with open-ended questionnaires resulted in good quality formal data which was informative and relevant to the research question.

Smith (2004) argues that the richness of participants’ responses in qualitative studies will be related to the importance of the experience being explored and their engagement with the project. The current study’s findings suggest that Smith’s claims may be applied to written data collection methods, provided they are planned and executed with particular attention and consideration placed on participants and research contexts. This point is further corroborated by the fact that on submission of their data, many participants thanked the researcher for allowing them to participate and provided permission for them to be contacted again if further clarification and/or elaboration were required. These methods may also have provided participants the opportunity to take part in a study that was important to their professional lives, and that might not have been possible using other less convenient methods.

The E-mail open-ended questionnaire method has been successful in this project but effort was made to incorporate guidelines and advice from existing literature on FTF interviewing, E-mail interviewing, and internet and other online automated recruitment and data gathering. It might be said that just as FTF interviewing and E-mail interviewing is said to be a craft that relies heavily on the skills of the interviewer (Hamilton & Bowers, 2006) then data gathering via E-mail and computerized open-ended questionnaires may be one more craft of qualitative research that could be nurtured and developed. The utility of such methods may become increasingly important and beneficial in the quickly expanding automated arena of health research in an era where time, expertise, experiences and other resources may become ever more difficult to access for practitioners and researchers alike.

5.12 Utilising open-ended questionnaires for reflection and learning

Participants reported that participation was a positive experience and that it deepened and consolidated their MI learning. Participants commented on the fact that writing the diary brought about learning and development that otherwise would not have happened and that actually writing it was important (see appendix 4.1). Trainees in future programmes could be informed about this and encouraged to keep reflective diaries or to at least perform some written reflective exercises.

That learning is facilitated is not surprising in the reflective diary component as their purpose is to facilitate learning, but it is more so in the questionnaire component. For some participants completing the open-ended questionnaire encouraged reflection and consolidated learning even three years after their training workshops. This suggests that respondents experienced their participation as a learning process that brought about change. It is suggestive of what Patton (2002) refers to as 'process use' of an evaluation process, whereby participants benefit from the evaluation process. Patton describes developmental evaluation whereby 'process use' results in "ongoing learning, internal improvement, and program development rather than generating reports and summative judgments for external audiences or accountability" (p. 180). Taking this further Patton (2002) discusses action research and action learning as models for evaluating and developing educational programmes. He states that such enquiry can result in twofold learning opportunities. Firstly it can derive insights and findings that may change trainers and program coordinators practice and training programme content. Secondly those who participate, in this case the trainees, learn how to systematically reflect on what they are doing, and on their relationships with colleagues and others with whom they work. Whether open-ended questionnaires distributed via email could be used as a reflective tool to facilitate such developmental processes in MI training could be explored in future work. Thus questionnaires could be electronically distributed at different time intervals, and trainees encouraged to reflect upon and complete them for their *own* development.

Finally, these findings suggest that the research process was a positive and personally enhancing experience for participants, bringing about further reflection, learning and personal development. This evidence can be utilised in future ethics applications, and participant information sheets to encourage clinicians to participate in future projects of a similar nature.

The main strengths and limitations of the current study will now be outlined.

5.13 Strengths and Limitations

In relation to the study's strengths, the theoretical underpinnings of the TA, and the process used to derive themes have been described in detail, both qualities of a good TA that are often overlooked (Braun and Clarke, 2006). It also describes in some detail the researcher, the trainers, the trainees, the training contexts and the training programmes from which participants were recruited, which is expected if excellence is to be demonstrated in contextualist research (Willig, 2001). This contextualising further enhances external validity, and addresses the shortcoming of much of the existing MI training literature. It also addresses necessary elements of behavioural interventions which are overlooked by current reporting guidelines (Davidson *et al,* 2003; Des Jarlais *et al,* 2004; Downs & Black, 1998; Glasgow *et al*, 2002; Khan & Kleijnen, 2001; and Petticrew & Roberts, 2006).

As outlined above the study overcomes the shortcomings of previous MI training studies raised by Madson et al (2009) and explores constructs such as confidence and identity which have previously been overlooked.

As already discussed in chapter 3, Yardley's (2008) criteria for enhancing quality and rigour were met both implicitly and explicitly. In particular a deviant case analysis was performed, numerous methods and sources of triangulation were utilised, saturation of themes was attained, and the participants were consulted on how they experienced the research process.

Finally, Larkin and Griffiths (2002, p. 308), suggest that arguments surrounding data collection methods equate to issues associated with "levels of transcription". They

posit that instead of attempting to provide an “objective” account of data, researchers should provide a “plausible” account, illustrated clearly with transparent evidence. The inclusion here of verbatim quotes provides a transparent plausibility. Larkin and Griffiths also argue however that “transcript excerpts are perceived as though 'unfiltered' - they have a persuasive quality which suggests that the map is a much closer fit to the territory than it often is.” (p. 309). While filtering was done in choosing which excerpts to include, it could be argued however that in using respondents’ written accounts rather than transcripted interview data, the transparency of the current study’s data is stronger than that of either transcribed interview or observational data.

In relation to limitations, although an initial model of the experience of learning MI has been presented using the findings of this study, due to response bias, it is not complete. There was a noticeable absence of negative experiences and clinicians working in acute settings. Although some hypotheses relating to the low response rate were discussed earlier in Chapter 3, these involved mainly contextual and temporal related variables, and the following should also be considered. It may be that only those who found the courses a positive experience and who recognized the benefits of changing clinical practice chose to participate in this study. It may also be that those in the acute setting saw less relevance for their practice or found it more problematic to put their learning into practice in their professional setting. The latter hypothesis is corroborated by feedback provided by one nurse participant who despite using HBC methods successfully in a rehabilitation context, found it difficult to put into practice when she returned to work in an acute setting when her secondment ended. The lengthy participant information sheets may have been off-putting, and although difficult to achieve in terms of fulfilling NHS ethical requirements, future studies should endeavour to keep these as short as possible.

Although a deviant case whose experience was different from that of other participants was identified, analysis of this participant’s data revealed that while her learning had not occurred as she had desired and expected, she nevertheless viewed MI positively and her tone was one of regret and disappointment. There may have been other trainees with similar experiences who did not feel able to participate due

to their negative experience of learning MI. If this is the case, then their absence prevents exploring whether a relationship exists between these clinicians and their experience (e.g. factors relating to personality or work contexts), whether they are identifiable during training, and how to begin to improve their experience. Likewise the absence of clinicians from acute settings and those with negative views of MI or the training render the findings partial. Without this understanding it is not possible from this study to establish MI's relevance to such professionals, nor to suggest what can be done to improve their experiences and the accessibility of MI for them.

Likewise the 'saturation' of themes is also limited by the response bias. Although latter cases analysed no longer brought additional insights to the research questions, saturation in the current study is constrained by the data obtained and by the researcher's analysis and interpretations. Although this constraint is acknowledged here, as already discussed, in an interpretative study this is not an issue as the themes obtained are always partial and contextual, and another researcher with a different background or other data collection methods such as interviewing, with a different sample in another context, may have obtained additional themes. Nevertheless the fact that saturation of themes occurred increases rigour within the current sample. Further, saturation is a term borrowed from grounded theory which uses theoretical sampling iteratively until no new theoretical insights are obtained (Charmaz, 2006). Even in grounded theory however findings are always provisional and saturation is considered a goal rather than a reality, as emphasised by Glaser and Strauss (1967, p. 40) who stated that "the published word is not the final one, but only a pause in the never-ending process of generating theory."

One final note on the sample bias, Smith et al (2009, p. 49) remind us that in qualitative research participants "'represent' a perspective rather than a population". This is particularly apt for a contextual interpretative study and the sample bias is merely reflected upon here as a potential limitation and to highlight potential alternative views. It does not however render the findings of the current study weak as they represent "a perspective" on the experience of learning MI.

Bolger et al (2003) advise that when using diary methods, the researcher should decide upon and make explicit the rate and timing of responses. Although this was done, the diary instalments were mostly infrequent and irregular and the researcher often had to remind and prompt participants to complete them. In future studies it would be advisable to encourage more conscientious completion of diaries by being more proactive in collecting journal data, and participants should be instructed to expect reminders.

The diaries although detailed did not always provide material relevant to the current study. Long segments were written describing consultations in detail and much was written about joining new teams and supervision experiences. Although this data was very rich and informative, and there was much relating to the research questions, there was also a large amount that had little relevance to MI theory and skill building. Some diaries were very descriptive and not always particularly reflective. This suggests that some education on how to make the most of reflection may be beneficial in future training programs. For future research it may also be helpful to be more directive and specific about what should be written about, and to stipulate how often this should be done. This may however run the risk of compromising the reflexive utility of the diaries for the participants' development, and this should also be considered in future projects.

Although a further strength of the study, the data obtained was broad, detailed and deep, and managing this data and the findings was extremely cumbersome and overwhelming. The richness and volume of themes found was not anticipated and in future studies automated packages such as Nvivo could be utilised to overcome this problem.

Chapter 6 Reflections on the Research Methodology

Contents

My background and foreknowledge was discussed in Section 3.2, and the purpose of this chapter is to provide a reflective overview of my epistemological and methodological journey as the project progressed, and of the potential impact I had upon the participants and therefore the project. As before it makes sense for me to write this chapter in the first person.

6.1 Thematic Analysis Vs Interpretative Phenomenological Analysis

Although my initial intention had been to utilise IPA, in 2007, after I had completed data collection, I read Braun and Clarke's (2006) article which discussed TA as a methodology in its own right. I began to question the extent to which IPA differs from TA when it is used interpretively, and whether TA would be a more suitable methodology for my project. I took these questions and reflections to several meetings of an IPA forum chaired by leading IPA promoter and researcher Prof. Paul Flowers. This led to one meeting being dedicated exclusively to the discussion of the Braun and Clark paper. Although I came to understand more fully why TA was more appropriate, initially I chose TA due to its apparent flexibility and transparency and in order not to be held back by my concerns that arose during these meetings relating to whether my data was rich enough to produce phenomenological insights. Nevertheless I continued to read about and elaborate my understanding of both TA and IPA.

I have learned that the decision to use TA in the current project had many benefits over IPA. Firstly although IPA promoters encourage using novel data collection methods, I came to realise that parts of my open-ended questionnaire produced non phenomenological themes, which while interesting and relevant to the current research questions and MI training, rendered some of the findings descriptive and difficult to justify in an IPA analysis. This realisation that some of my findings were more in line with TA than IPA allowed me to come to understand what the difference between IPA and an interpretative TA is. IPA is a methodological approach with phenomenological, experiential, hermeneutic and idiographic theoretical underpinnings, requiring extremely open ended data collection methods such as face-

to-face interviews. Additionally IPA is perhaps more relevant when researching phenomenon that have a highly personal and often sensitive nature such as personal illness. This is not to say that learning MI is not experiential or phenomenological but the manner in which I decided to explore this learning experience resulted in the data that was more descriptive at times and thus not entirely in line with IPA and its theoretical underpinnings. A different data collection method such as interviewing may have obtained deeper experiences and insights, but this may have increased researcher bias, particularly when some participants knew me and me to them. Ultimately I believe that the insights obtained have pragmatic benefit for MI training.

Secondly, Willig (2001) suggests that researchers would choose IPA over GT because IPA is a specifically psychological method which has more potential for creativity and exploration, and because there are many debates and controversies associated with grounded theory which lead to its application being challenging. However IPA is not without critique. IPA has been criticised as being not scientific due to its attempt to be non-prescriptive, and as being misnamed due to it being experiential rather than phenomenological (Giorgi, 2010). Willig further claims that GT now has several versions and researchers would have to engage with the debates relating to these before they could choose and justify which approach they would take. My attendance to the IPA forum meetings revealed internal debates with different views on whether more than one questions could be posed during interviews to avoid compromising or biasing the data obtained. This debate is not mentioned in any of the currently existing IPA literature. Considering this and given my use of a semi-structure questionnaire, again its applicability to an IPA approach may not have been tenable.

Thirdly, a recent review by Smith (2011) provides guidelines for assessing and reporting IPA studies. Of 51 IPA studies exploring physical health issues, 14 are classed as good, 28 as acceptable, and 9 as unacceptable. Amongst other criteria Smith mentions that papers with a broad rather than focussed investigation would be less likely classed as acceptable. My study was broad and exploratory from the outset, therefore again an IPA approach would not have been appropriate using these current assessment criteria. Smith further suggests that as qualitative researchers and

IPA researchers in particular becomes more skilled and sophisticated, the quality of work will rise, potentially rendering studies currently graded as acceptable becoming unacceptable in future reviews. This is unfortunate since these studies and those currently being classed as unacceptable most likely have produced useful and insightful TA's which may be ignored or dismissed as IPA standards rise.

To conclude I believe my methodological questioning, exploration, reflecting, and decision making has led to a rigorous and thought-provoking TA which has provided pragmatic insights into the experience of learning MI.

6.2 Multiple Roles and Potential Researcher Influences

As already stated I believe that many of my own preconceptions only became known to me as I performed the analysis. This does not however mean that these did not impact the findings particularly in relation to the interpretations I made. Another researcher in another context may have chosen different data collection methods which may have led to data of a different quantity and quality, and hence different findings. They may also have made other interpretations. They may have focussed on and discussed different aspects of the findings, and they may have chosen to relate the findings to other theories, models and areas of health psychology. For instance a cognitive psychologist may have chosen to focus more on other cognitive models like the DPR model discussed above in relation to learning CBT. Hence other hypotheses for future research may have been produced. Indeed it is entirely possible that another deductive analysis of the data using such models could produce further insight into the experience of learning MI, and how to facilitate it.

Further, I may have impacted the study through the influence I may have had on the participants. This may have happened in two ways and some participants may have been affected by either one or both of these influences. Firstly as already mentioned participants may have chosen to participate or not to participate due to knowing me as the researcher. What they chose to disclose or not to disclose could also have been influenced by this acquaintance. They may for example, have chosen not to tell me

about more negative experiences in order to avoid embarrassment or in order to avoid offending me or the other trainers who they might have expected to be reading this report. Secondly since I was a practising clinician and colleague of several of the participants, and since the study has found that observing peers and others influences learning, then it is entirely possible that I may have influenced the learning experiences that were reported. Thus knowing and working with me may have impacted their learning and practice, how and what they wrote, and the content and tone may have been different had I not been present or known to them.

Chapter 7 Conclusions

Contents

The following outlines the conclusions drawn and recommendations that can be made from the current study. Finally a short statement will be made proposing the theoretical and clinical implications and impact that the thesis has already made.

7.1 Concluding remarks

To conclude, this study has presented a richly detailed analysis of how learning MI is experienced by multi-disciplinary health professionals from the perspective of the professionals themselves, as elicited and interpreted by the researcher. While the interpretative nature of this research and methodological limitations constrain the conclusions to be drawn, this study has provided information on key processes and elements of learning MI, and some implications for future MI training and research efforts which are summarised in appendices 7 and 8. Since the participants self selected and it appears that those who participated had a positive attitude towards MI and their learning, caution should be taken in making more general claims about how this process is experienced. Further research is required to explore more negative experiences and whether similar experiences to those reported here occur in other settings.

Nevertheless the findings provide insights into the experience of multi-disciplinary health professionals learning MI before, during and following training workshops. The themes found highlighted that this learning journey is an emotional and challenging experience which may temporarily compromise professional identities, and which is time consuming and in some cases was still in progress after 3 years. The many and varied ways that the learning process may be facilitated or hindered, and the importance of practicing with real clients, and of having available various forms of supervision and support and other reflective practices, were highlighted.

The findings triangulate with many aspects of the existing MI training theory. They also extend this by explaining some of the processes that learning MI involves and by describing the previously undocumented emotional aspects of learning MI. The study suggests how shifts in professional identity and feelings of being deskilled

occur. If these are not remedied through appropriate reflective practices such as supervision, the risk of decreased motivation and job satisfaction increases. Learning and practicing MI was also experienced as a physically and mentally demanding process for the health professionals.

When MI skills are developed and practiced participants reported many benefits for both themselves and their clients. This in turn led to them finding their job less stressful, and they experienced feelings of increased professional skill and effectiveness, and increased job satisfaction. When entire teams had been trained, participants perceived improved teamwork and reported culture change within the team. Some pros and cons that this culture change brought for existing and new staff have also been highlighted.

Participants' reports suggest that MI is perceived as powerful. This raises concerns relating to 'opening a can of worms' that cannot be managed, and may lead to non practice. It is recommended that in many settings onward referral pathways be set up, and that training in managing sensitive disclosure is provided as part of MI training.

The foregoing highlights the need for clinical supervision and emotional support when learning MI and this may not always be recognised or desired by trainees and their managers. The inclusion in policy documents such as "The Matrix" (NHS Education for Scotland, 2008) of MI as a psychological intervention requiring clinical supervision may go some way to remedying this concern. The apparent commonality in experience between learning MI and learning CBT also suggests this inclusion may be pertinent. However, in line with CBT and other psychological therapies, accreditation bodies and schemes may be required to ensure attainment of MI skill and adherence.

The study has posited an elaboration of the four stages of learning model of adult skill building. It is suggested that the third and four stages, *conscious competence* then *unconscious competence*, may be juxtaposed, and that *unconscious competence* may not be a desirable aim in relation to learning therapeutic consultation skills such as MI. Additionally the ripples model of adult learning (Race, 2005) and how it

theorises ways of facilitating the learning process were particularly evidenced in participants' reports, and this model fits well with MI training. Following this model recommendations are provided for increasing, the perceived need for and desirability of MI training for potential trainees, and for increasing engagement during and after workshops when they attend. Key constructs from other learning theories such as the ZPD, scaffolding, the zone of reflective capacity, and role modelling may also be used to inform the delivery of MI training programmes and follow-up support. In this sense issues surrounding the generalizability of the study may be less relevant, as the findings have utility from a pedagogical perspective for MI trainers.

Relating to methods and methodology, it is hoped that the study has also conveyed how electronic data collection methods and open-ended questionnaires and reflective diaries have utility in qualitative studies of this nature. The data obtained was rich and of good quality. The participants found making their contributions helpful in developing their MI skills, indicating both their utility in learning and training as well as in research projects. These methods are cheaply utilised, and, by providing participants privacy, and autonomy and choice about when and what they contribute, they are ethically sound and they potentially reduce the risk of researcher bias. This study therefore argues that the use of electronically written and distributed data collection methods are appropriate for qualitative research, provided the data collection methods used are best suited to a given research question and context, and that they are planned and executed well. Additionally, these findings suggest that the research process was a positive and personally enhancing experience for participants, bringing about further reflection, learning and personal development. This evidence can be utilised in future ethics applications, and participant information sheets to encourage clinicians to participate in future projects of a similar nature.

The study also highlights that qualitative research that asks the participant to reflect and articulate their experience, has the potential of changing that experience. This has implications for research but is not necessarily problematic as long is it is acknowledged. It may also have utility in participatory action research projects, (Patton 2002; Yardley, 2000) where qualitative research aims to evaluate

interventions and provide solutions. While the use of reflective diaries is an established tool for developing learning, the potential utility of open-ended questionnaires as a reflective tool used to enhance experiences such as training and learning should be investigated.

7.2 Impact

The findings of this study have impacted further MI training programmes which the researcher has been part of. These training programmes appear to have been successful and have resulted in oral and poster presentation at international conferences. It is expected that further publications and presentations will result when a fuller evaluation has been completed. In addition to this 2 systematic reviews of MI adherence measures have been competed one of which has been published in an international peer reviewed journal.

In reviewing the MI training literature when preparing this thesis, it was decided to systematically review the psychometric properties of existing MI adherence measures (Turner & Wallace, 2009; Wallace & Turner, 2009). These reviews suggested that the existing measures were not fully validated and that caution should be taken when drawing conclusion from any study that utilises them. The current researcher has not observed any further work being completed on the measures reviewed and it is hoped that these reviews will impact the MI research community, and that further development and testing of MI measures will result as a consequence.

Due to the experience and knowledge gained in conducting this thesis and in the training carried out as part of his Professional Doctorate in Health Psychology, the current researcher was invited to be part of the AsSET (Astley Ainslie pSychological Skills and Education Training) training service. AsSET was developed to train health professionals in Health Behaviour Change methods to promote healthier living and better management of chronic conditions.

To date as part of AsSET, the researcher has co-developed and conducted a year long training programme, training four teams comprising in total 60 health professionals. The content of this programme was adapted from the Cardiac Training program from which participants in this study were recruited. Many of the adaptations made were based upon recommendations of the current thesis. Although a full evaluation report will not be completed until mid 2011, preliminary evaluations (Nicklas, Torrens, Kunkler, Wallace, Taylor, & Scopes, 2010a, 2010b; O'Brien, 2010; Torrens et al, 2010), anecdotal evidence and personal observation indicate that the incorporation of these recommendations may have led to an extremely successful training endeavour. The adaptations and the observations made relating to them include:

- An attempt was made to train whole teams, and this was a requirement for participation in the programme. The managers helped to motivate staff by marketing the training as a privilege, and as high quality training that they would be lucky to receive. One team which did not work as a fully cohesive team with one manager, did not so readily engage with the training, had higher dropout, and did not attend supervision as frequently as the other three teams.
- Monthly supervision and support was provided to each team for 6 months following training workshops. The nature of this supervision and its aim to facilitate the professional development of trainees was explained during training workshops. Supervision was well received and engagement with the process and attendance was higher than was expected based upon the existing MI training literature.
- The need for reflection in adult learning was also explained and several exercises and tools to facilitate reflection were provided. Team managers observed increased reflection and discussion about practitioners' interaction styles within their teams.
- Trainees were informed about the potential of experiencing reduced confidence and feeling deskilled. This was not raised as an issue either during training or afterwards, and it appears that this expectation and knowledge may have resulted in such experiences either not occurring or occurring in a

minimally bothersome way. The proposed 8 stages of learning MI were outlined, and the trainees reported finding this helpful in assessing where they were and in normalising their experiences.

- The training provided education, tools and guidelines for assessing depression and anxiety in adults with chronic physical health problems (NICE, 2009), and introduced a referral pathway for complex patients using a stepped care model. This was to address concerns relating to sensitive disclosure and feeling out of one's depth. Trainees reported in supervision that they were more able to identify mood problems and were more confident in referring patient on to more suitably qualified health professionals or back to GPs. Managers felt that as their staff practiced and developed skills, their confidence grew and they were better able to manage more complex patients.

Preliminary evaluation of this training programme has also resulted in one oral and one two poster presentations at international conferences (Nicklas, Torrens, Kunkler, Wallace, Taylor, & Scopes, 2010a, 2010b; Torrens et al, 2010).

Table 7.1 Papers and poster presentations indicating the impact of this thesis

O'Brien, G. (2010). *A qualitative exploration of managers' perceptions of AsSET Training.* Doctorate submission. Edinburgh University.
Nicklas, L., Torrens, L., Kunkler, J., Wallace, L., Taylor, L., & Scopes, J. (2010a). *ASSET: Meeting the needs of staff supporting patients with LTCs in the community.* Poster presented at Long Term Conditions Collaborative Final Year Conference: Passing the Baton, Edinburgh, Scotland.
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Torrens, L., Nicklas, L., Scopes, J., Kunkler, J., Taylor, L., Wallace, L., et al. (2010, May 11). *ASSET.* Paper presented at International Conference on Support for Self-Management of Health, Stirling, Scotland
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Appendices

Contents

Appendix 1: Theories of Adult Learning

Theories of adult learning have been the focus of much research and attention over the last 20 years as learning has become recognized as being a lifelong process. This appendix outlines some of those which are noteworthy for the current study.

Experiential Learning

Kolb (1984) describes an 'experiential learning cycle' whereby adults learn by trying things out, reflecting on how things went, theorizing and forming cognitions, making adjustments, and then trying things out again.

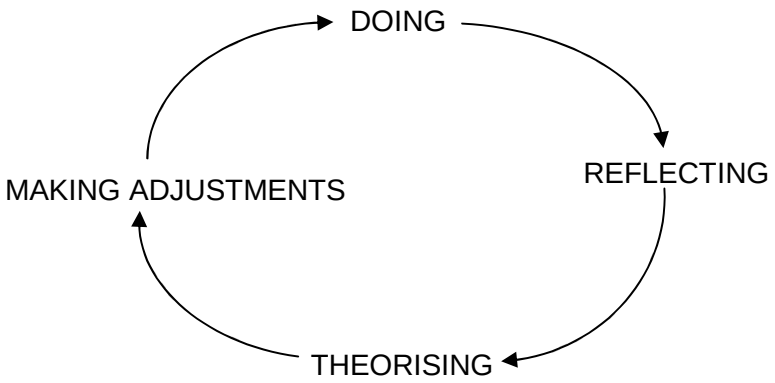


Figure A.1 Kolb (1984) - Experiential Learning Cycle

Kolb's model emphasizes the need to engage actively with the material to be learned. For genuine learning to occur a cycle of experience, practice, observation and reflection on the experience, forming concepts and generalizations, and planning to test concepts may be repeated several times. Atherton (2005) states that using this model a tutor or mentor's principle aim would be to 'chase' learners round this cycle asking questions which would encourage reflection, theorizing and ways of testing out ideas.

Although widely recognized and utilized Kolb's model is not without problems nor dissention. Race (2005) suggests that learning is not cyclic and does not occur in different stages that follow on from or are dependent on each other. Race proposes five factors that underpin successful learning:

- *Wanting to learn* – the desire or an 'intrinsic motivation' to learn something
- *Needing to learn* – the responsibility taking or 'extrinsic motivation' to learn something
- *Learning by doing* – learning through practice, experience, repetition, and trial and error.
- *Learning through feedback* – Race proposes that feedback is linked to *learning by doing* and is most facilitative if received either as part of or temporally close to the practice. Feedback can arise from many sources and at many opportunities. Feedback can be received as constructive critical feedback from mentors, teachers, trainers, and others, but also intrinsically through one's own and others' reactions when doing something.
- *Making sense of things* or *digesting* – this is the process which turns information into knowledge and understanding. Race proposes that this process is the most important and is strongly connected to all the other factors.

Race states that these factors or processes may occur simultaneously and in no particular order. He proposes a ripple model of learning whereby like ripples in a pond, these factors move backwards and forwards interacting with each other. See Figure 2.

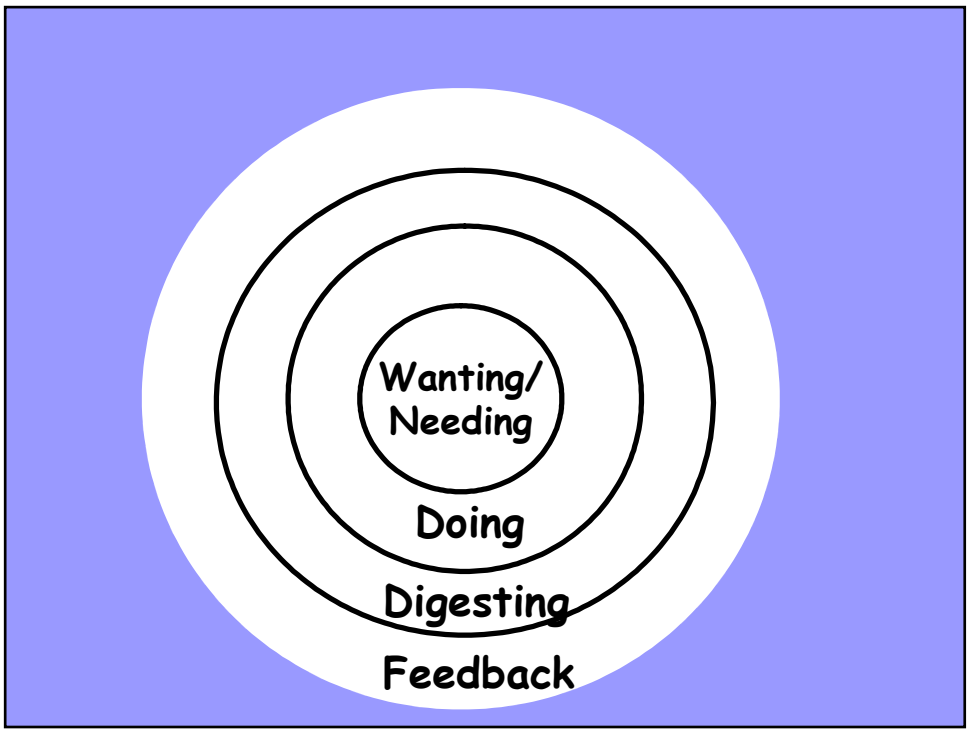


Figure A.2 Race (2005) - Ripples Model of Adult Learning

So in Race's Ripples Model of Adult Learning, rather than reflection being a separate process that happens *after* doing something; reflection, feedback and digestion are processes that may overlap and may occur *while* doing something.

Constructivism

Constructivism is "the process of building up your own knowledge by connecting new information with what you know already and forming concepts that are models of reality", (Morss and Murray, 2005, p. 14). Kolb's and Race's models fit with constructivist theories which, simply put, claim that new knowledge is built upon existing knowledge structures. So individuals learn through a process of making sense of and connecting new information using their own already existing knowledge. Since individuals have unique experience and knowledge, constructivism implies that we would individually structure our learning and for this to happen we have to take an active role in our learning. This is another justification for having learners participate actively in their training.

Social constructivist theories (Vygotsky, 1978) emphasize the role of social interaction in learning. Vygotsky's concept of the 'zone of proximal development'

(ZPD) emphasizes how children learn through being helped or 'scaffolded' by another whose skill in what is being learned is higher than their own. Thus the ZPD relates to what one can do with the help of another, and is a stage towards doing something on one's own.

Biggs (2003) suggests that good teaching principles and practice will ensure that students build on what they already know, and requires "relevant activity from students, interaction with others, and self-monitoring" (p. 74). Biggs asserts that students need "to do things that directly address what we want them to learn (p. 81)", and that interaction with each other greatly increases the options available. He states the teacher's role will vary from "highly directive, specifying procedures and correcting errors, to supervisory, to consultant to group leader" (p. 74).

These models highlight that learning will be most effective when 'theory to practice' links are built into the training. Taking time to reflect after trying a new skill and recording observations are examples of how this can be done in the workplace. In this way constructivist theories are implicit in learning through reflective practice which is discussed below.

Social Learning Theory

The social learning theory of Bandura (1977, 1986) highlights the importance of learning from and interacting with others, and of observing and modeling the behavioral, emotional, and attitudinal repertoires of others. Thus human behaviour is explained in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental impacts. In emphasizing the role of social learning, Bandura's theory is related to that of Vygotsky.

In Bandura's model, individuals are more likely to adopt a modeled behaviour if the model is admired and the behaviour has functional value that results in outcomes they value. Thus social learning theories emphasize the important role in learning and skill building, of observing the behaviour of more experienced others and being given the opportunity to model these oneself. Additionally Bandura's model suggests

that vicarious learning may occur through peer tutoring, peer discussions or during group work

Four Stages of Competence Model

The source of this model is unknown but it is often referred to in mentoring and training literature. The model purports that learners pass through four states of consciousness and competence when learning a skill (Howel, 1982; Flower, 1999). The four stages are:

1. *Unconscious incompetence* occurs when an individual is unaware of what the don't know or can't do, and thus has no motivation to address this deficit;
2. *Conscious incompetence* occurs when an individual knows they don't know something and is thus aware that a lack in knowledge, skill and ability exists;
3. *Conscious competence* occurs when a learner knows how to do something but demonstrating the skill or knowledge takes consciousness effort or concentration; and
4. *Unconscious competence* occurs when an individual has practiced a skill extensively until it has become automatic or 'second nature' and the knowledge, skill and ability can be demonstrated without conscious awareness or concentration.

	Incompetent	*Competent*
Conscious	**Conscious Incompetence**	**Conscious Competence**
Unconscious	**Unconscious Incompetence**	**Unconscious Competence**

Figure A.3 Four stages of Competency Model table

Reflective learning

Kolb's (1984) cycle of adult learning, emphasizes the need for active learning and reflection to assimilate learning with prior knowledge and experience. Boud *et al*

(1985) suggest that time should be built into training to allow for reflection which can be achieved through discussion, debriefing with others or through keeping reflective diaries. Trainers can facilitate this by helping learners to objectively articulate experience, to pay attention to their feelings and then to assimilate their learning within their work context.

Schön (1983) argues that theoretical knowledge, such as that imparted on training courses, is not always readily applied to the non-textbook problems encountered in real life, such as a patients' predicaments. His recommendation that reflective practice is a key skill within adult learning is increasingly recognized as a way to bridge the theory into practice gap.

The learning models outlined in this appendix are not mutually exclusive and they complement each other. They highlight that learning will be most effective when 'theory to practice' links are built into the training. Facilitating, encouraging and supporting active participation and practice should be incorporated in to training programmes, and appropriate feedback and reflection opportunities should also be included or encouraged soon after training.

Appendix 2: Materials

2.1 Participant Information Sheets

Queen Margaret University College
EDINBURGH

NHS Lothian

Learning and Experiencing Motivational Interviewing (MI) Methods - A Qualitative Exploration

Participant Information Sheet – Diary Study

You are invited to take part in a research study. Before you decide whether you would like to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what your participation will involve.
- Part 2 gives you more detailed information about the conduct of the study.

Please don't hesitate to ask me if there is anything that is not clear or if you would like more information; my contact details are below.

Please take time to decide whether or not you wish to take part.

Part 1

Study Background and Aims

This study is being conducted to satisfy my research competencies for a Professional Doctorate in Health Psychology which I am completing with Queen Margaret University College (QMUC).

Increasingly non-psychologically trained health professionals are being trained in psychological models and are expected to become competent in psychologically informed therapeutic skills and consultation styles. However, very little research explores how these professionals manage this learning process, and how they as individuals and members of regulated professions experience this. This study aims to begin to fill this gap by exploring what individual and common experiences exist, and to begin to inform future training and research requirements in the area. Health professionals like yourself who have recently followed MI training programmes will be invited to reflect on their learning experience and to describe this by keeping a reflective diary. The broad research questions are:

> *How do non-psychologist clinicians learn and experience the use of Motivational Interviewing (MI) as a consultation model?'*
>
> *How does learning MI change their clinical practice?*

Depending on the data gathered and the emerging evidence, secondary research questions are:

How do they experience the learning process?
How can this process be hindered/facilitated?
How does this experience compare and contrast across:

- *Professions/Disciplines*
  i.e. consultant, physiotherapist, dietician, nurse, occupational therapist
- *Time*
- *Context i.e. in primary, secondary, tertiary care, acute and rehab settings, or across different illness treatment settings e.g. cardiac, chronic pain, & addictions*

Why are you being invited to take part?
You are being invited to participate because you have recently been recruited into the Lothian Cardiac Rehabilitation and Chronic Pain Management services and have taken part in the '*Training Course in Methods of Health Behaviour Change'* run by Nicola Stuckey as part of Lothian Cardiac Rehabilitation Redesign Project Directorate. You provide a potentially rich source of data since you have recently moved either from an acute or community setting into a rehab setting and beginning to work using a more psycho-educational model. As such you experience is particularly interesting to this study for you can provide a first hand account of how it is to begin working using a psychological model in a setting new to you.

You are invited to complete a reflective diary of your experience of learning MI for a 2-3 month period depending on the opportunity you have to practise MI and the degree to which you find keeping the diary a personally useful exercise.

Do you have to take part?
No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw and to have any data relating to you destroyed at any time and without giving a reason.

What do I have to do?
If you decide to participate you should print and sign 2 copies of the attached consent form. One copy should be kept by you for your own records. The second copy should be returned to me via the NHS internal mail at the address below **within one week of receiving this invitation** along with a completed participant data questionnaire which is also attached. If for some reason (e.g. due to annual or sick leave) this is not possible within this time period and you still wish to participate please contact me to see if it is possible to include you. It is up to you to decide whether or not to take part. If you do, you should keep this information sheet with your records. You are still free to withdraw at any time and without giving a reason.

If you decide to participate you will be required have to keep a reflective diary for 2-3 months recording electronically your experience of learning and incorporating MI into your clinical practise. Whether the study period lasts 2 or 3 months will depend on the opportunity you have to practise MI and the degree to which you find keeping the diary a personally useful exercise.

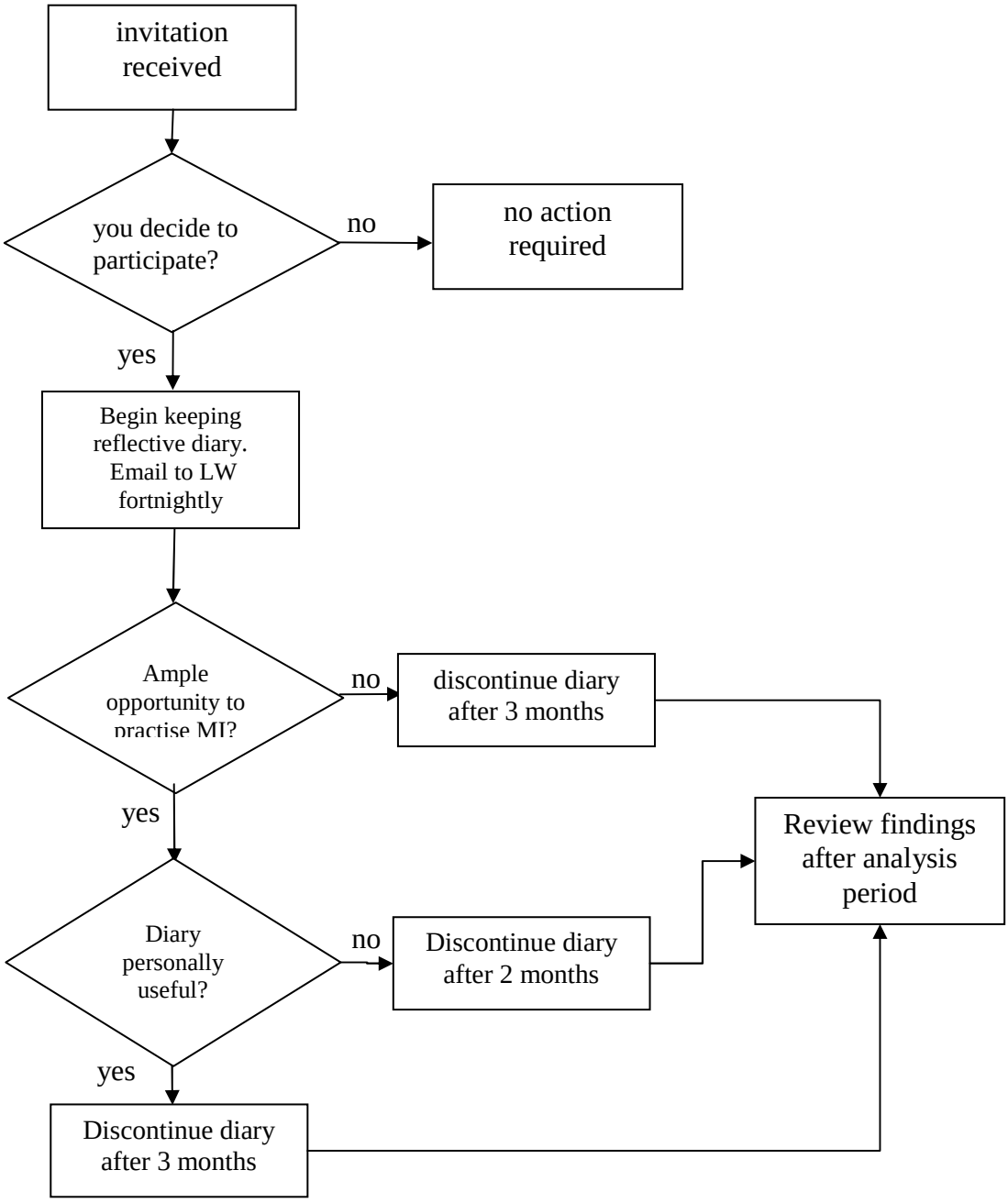
You will be encouraged to complete your diary often and to enter at least one A4 page of text per week. You will require some time to reflect and the completion of the diary is expected to take no longer than 30 minutes per week. You will be required to send me copies of your diaries via the NHS Email System approximately every 2 weeks until the end of the study period.

At a point between 1 and 2 months after you have submitted your last diary entry you will be invited to comment on the results of my analysis of your diary. This is called ‘member checking’ and is one method used to ensure quality in qualitative research.

If at any point during the study period you have any questions or require technical assistance you may contact me to gain this.

Below is a flowchart with possible routes to participation or non-participation, and what actions you need to take at each stage.

Flowchart showing selection and participation routes



What are the possible disadvantages or risks of taking part in the study?
Apart from the time take to reflect and complete the diary I do not believe there are any disadvantages or risks attached to participating in the study.

What are the possible benefits of taking part in the study?
I cannot promise the study will help you but the information we get might help improve the training of future clinicians.

You may however find it beneficial to reflect on your learning and experience with MI. It may also raise your awareness of what facilitates and/or hinders your learning and this may facilitate your CPD.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?
Yes. All the information about your participation in this study will be kept confidential. Further details are included in Part 2

Contact Details:
Please contact me if you have any questions or concerns about the study. Either at my work address above, via email Lloyd.Wallace@lpct.scot.nhs.uk or by telephone on 0131-537-9141.

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

What if there is a problem?
If you experience any problems or concerns relating to any aspect of this study you should contact me through any of the above means, and I will do my best to answer your questions (my contact no again is 0131-537-9141). If you remain unhappy and wish to complain formally, you can do this through either the NHS or QMUC Complaints Procedures. Details can be obtained from the hospital or the university.

Will my taking part in the study be kept confidential?
Yes. All information which is collected about you during the course of the research will be kept strictly confidential. If applicable: Any information about you which leaves the hospital will have your name and any other identifying data removed so that you cannot be recognised from it.

All procedures for handling, processing, storage and destruction of your data are compliant with the Data Protection Act 1998.

Your consent form and Participant Data Questionnaire will be collected in paper form via the NHS internal mail. Your open ended questionnaire will be collected electronically via the secure NHS Email System. This means that your data will not be anonymous to me but no one else will have access to data that may identify you.

On receiving your data all identifying data will be removed and a unique Participant Reference No. will be assigned to it. A cross reference between Participant Reference No. and personal identifying data will be held manually in a file which will be kept in a locked filing cabinet in my NHS work place.

The anonymised data will be held on my secure 'Personal home drive' on the NHS Local Area Network (LAN)

For analysis it will be required to produce a hardcopy of your data. This hardcopy will be kept in a locked filing cabinet in my home or NHS work place. My academic supervisors may require to view your data but they will only have access to it after it has been anonymised.

Your data will be retained for seven years as required by the university and research bodies. After this period data held in paper format will be shredded and that held electronically deleted from the NHS LAN.

If you join the study, some parts the data collected for the study may be looked at by representatives of regulatory authorities and by authorised people from (the Trust, and other NHS bodies) to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and nothing that could reveal your identity will be disclosed outside the research site.

What will happen to the results of the study?

As part of my doctorate requirement the results of the study will be written up in the form of a dissertation report. It is also expected that the results will be written up and submitted to relevant peer reviewed journals for publication.

As is normal with qualitative research reports, findings are grounded with examples therefore excerpts from your data may be included. Care will be taken that nothing that is entered on these reports will identify you. My approach will be tactful and I will be mindful of professional, employee/employer and inter disciplinary sensitivities. I am aware of the issues related to public confidence in the NHS and NHS employees standing, and will endeavour to ensure that nothing is disseminated into a public arena which may jeopardize these.

If you would like to receive a copy of these reports please indicate this on your Participant Data Questionnaire.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS by the Lothian Research Ethics Committee and by the QMUC Ethics Board.

If you decide to participate please:

- ***complete the Participant Data Sheet which accompanies this information sheet,***
- ***complete and sign <u>two copies</u> of the following consent form,***
- ***keep one copy of the signed consent form for your own records, and***
- ***send the 2nd copy along with the completed participants information sheet via the NHS internal mail to me at the address below.***

Lloyd Wallace
Health Psychologist in Training
Dept of Clinical Psychology
Astley Anslie Hospital
133 Grange Loan
Edinburgh, EH9 2HL

***You may contact me via email address Lloyd.Wallace@lpct.scot.nhs.uk or by telephone on* 0131-537-9141**

Finally I wish to thank you for considering taking part and taking time to read this information sheet

Lloyd Wallace
Health Psychologist in Training

Queen Margaret University College
EDINBURGH

CONSENT FORM

Centre Number: : **Study Number:**
Partipants Identification Number (to be completed by researcher):
Title of Project: Learning and Experiencing Motivational Interviewing (MI) Methods - A Qualitative Exploration
Name of Researcher: Lloyd Wallace
Please initial box

1. I confirm that I have read and understand the information sheet dated …./…./…….. (version .....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
3. I understand that data collected during the study may be looked at by responsible individuals from [regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
4. I give permission for data that I provide to be quoted verbatim in reports produced from the study	☐
5. I agree to take part in the above study.	☐

_____	_____	_____
Name of Participant	Date	Signature
Lloyd Wallace	6/11/2006	L Wallace
_____	_____	_____
Researcher	Date	Signature

When completed, 1 for patient; 1 for researcher site file;

Queen Margaret University College
EDINBURGH

NHS Lothian

Learning and Experiencing Motivational Interviewing (MI) and Methods of Health Behaviour Change (HBC) - A Qualitative Exploration

Participant Information Sheet – Questionnaire Study

You are invited to take part in a research study. Before you decide whether you would like to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what your participation will involve.
- Part 2 gives you more detailed information about the conduct of the study.

Please do not hesitate to ask me if there is anything that is not clear or if you would like more information; my contact details are below.

Please take time to decide whether or not you wish to take part.

Part 1

Study Background and Aims

This study is being conducted to satisfy my research competencies for a Professional Doctorate in Health Psychology which I am undertaking with Queen Margaret University College (QMUC).

Increasingly non-psychologically trained health professionals are being trained in psychological models and are expected to become competent in psychologically informed therapeutic skills and consultation styles. However, very little research explores how these professionals manage this learning process, and how they as individuals and members of regulated professions experience this. This study aims to begin to fill this gap by exploring what individual and common experiences exist, and to begin to inform future training and research requirements in the area. Health professionals like yourself who have recently followed MI or Methods of HBC training programmes are invited to reflect on their learning experience and to describe this by completing an open-ended questionnaire. The broad research questions are:

> *How do non-psychologist clinicians learn and experience the use of Motivational Interviewing (MI) or Methods of Health Behaviour Change (HBC) as a consultation model?'*

How does learning MI change their clinical practice?

Depending on the data gathered and the emerging evidence, secondary research questions are:

How do they experience the learning process?
How can this process be hindered and/or facilitated?
How does this experience compare and contrast across:

- *Professions/Disciplines*
  i.e. consultant, physiotherapist, dietician, nurse, occupational therapist
- *Time*
- *Context i.e. in primary, secondary, tertiary care, acute and rehab settings, or across different illness treatment settings e.g. cardiac, chronic pain, & addictions*

Why are you being invited to take part?
You are being invited to participate because you have taken part in either the *'Training Course in Methods of Health Behaviour Change'* run by Nicola Stuckey as part of Lothian Cardiac Rehabilitation Redesign Project, or, the *'Introduction to Motivational Interviewing: A 3-Day Skills-Based Workshop'* run by Dr. Pete Littlewood and Sue Craufurd in the Substance Misuse Directorate.

These training programmes have taken place over a period of more than 2 years and provide an excellent opportunity sample of health professionals from different disciplines, illness, and treatment contexts and who have been learning these techniques over varying time periods. Everyone who completed the training is therefore being invited to participate.

Do you have to take part?
No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign and return to me the attached consent form. You are still free to withdraw and to have any data relating to you destroyed at any time and without giving a reason.

What do I have to do?
If you decide to participate you should print and sign 2 copies of the attached consent form. One copy should be kept by you for your own records. The second copy should be returned to me via the NHS internal mail at the address below **within one week of receiving this invitation** along with a completed participant data questionnaire which is also attached in a separate document. If for some reason (e.g. due to annual or sick leave) this is not possible within this time period and you still wish to participate please contact me to see if it is possible to include you. It is up to you to decide whether or not to take part. If you do, you should keep this information sheet with your records.

The returned participant data questionnaires will be analysed and a broad selection will be made across professions, contexts and time elapsed since training. By doing this it is hoped that many of the individual themes and commonality in experience, and changes over time will be identified. The number selected will depend on the mix of participants who choose to participate. At this stage it expected that approximately 20 participants will be selected.

If you <u>are</u> selected at this stage you will be sent an email informing you that you have been selected to take part in the study. An 8-item open-ended questionnaire will be attached

which you will be required to complete electronically and return to me via email within 2 weeks.

If you are not selected at this stage you will be informed of this. There may be a second wave of data collection and you may still be selected at a later date.

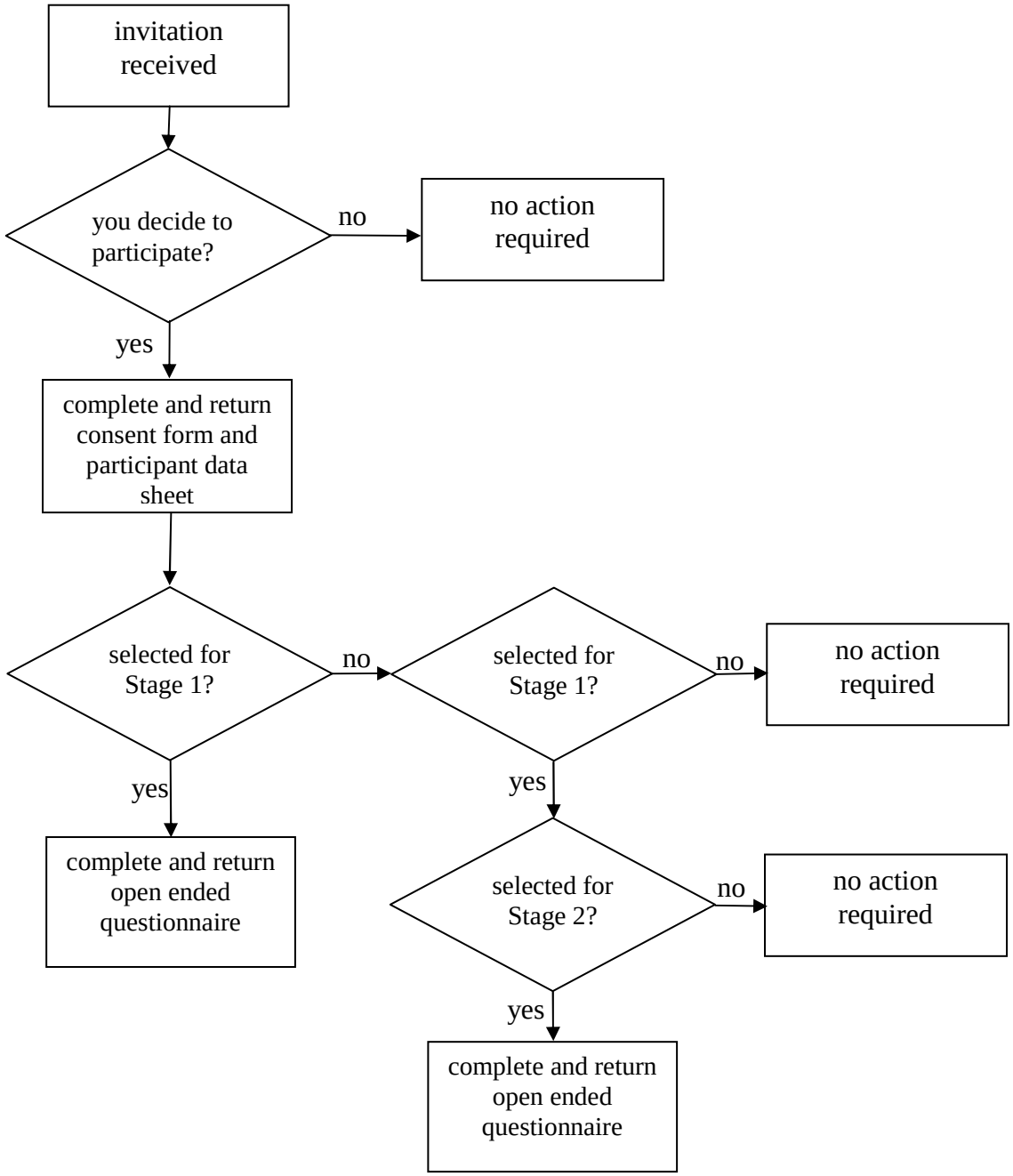
If further data collection proves to be necessary and you are selected in the 2nd wave then you will receive the email informing you that you have been selected to take part in the study. An 8-item open-ended questionnaire will be attached which you will be required to complete electronically and return to me via email within 2 weeks.

It is expected that you will need some time to reflect on your experience and that the questionnaire will take approximately 90 minutes to complete. It is felt that 2 weeks is sufficient time to allow for this. If 2 weeks does not prove long enough for you and you would still like to participate then this may be possible depending on what stage the analysis is at.

If you have any questions or require technical assistance you may contact me to gain this.

Below is a flowchart with possible routes to participation or non-participation, and what actions you need to take at each stage.

Flowchart showing selection and participation routes



What are the possible disadvantages or risks of taking part in the study?
Apart from the time take to reflect and complete the questionnaire I do not believe there are any disadvantages or risks attached to participating in the study.

What are the possible benefits of taking part in the study?
I cannot promise the study will help you but the information we get might help improve the training of future clinicians.

You may however find it beneficial to reflect on your learning and experience with MI and HBC. It may also raise your awareness of what facilitates and/or hinders your learning and this may facilitate your CPD.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Contact Details:
Please contact me if you have any questions or concerns about the study. Either at my work address above, via email Lloyd.Wallace@lpct.scot.nhs.uk or by telephone on 0131-537-9141.

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

What if there is a problem?
If you experience any problems or concerns relating to any aspect of this study you should contact me through any of the above means, and I will do my best to answer your questions (my contact no again is 0131-537-9141). If you remain unhappy and wish to complain formally, you can do this through either the NHS or QMUC Complaints Procedures. Details can be obtained from the hospital or the university.

Will my taking part in the study be kept confidential?
Yes. All information which is collected about you during the course of the research will be kept strictly confidential. If applicable: Any information about you which leaves the hospital will have your name and any other identifying data removed so that you cannot be recognised from it.

All procedures for handling, processing, storage and destruction of your data are compliant with the Data Protection Act 1998.

Your consent form and Participant Data Questionnaire will be collected in paper form via the NHS internal mail. Your open ended questionnaire will be collected electronically via the secure NHS Email System. This means that your data will not be anonymous to me but no one else will have access to data that may identify you.

On receiving your data all identifying data will be removed and a unique Participant Reference No. will be assigned to it. A cross reference between Participant Reference No. and personal identifying data will be held manually in a file which will be kept in a locked filing cabinet in my NHS work place.

The anonymised data will be held on my secure 'Personal home drive' on the NHS Local Area Network (LAN)

For analysis it will be required to produce a hardcopy of your data. This hardcopy will be kept in a locked filing cabinet in my home or NHS work place. My academic supervisors may require to view your data but they will only have access to it after it has been anonymised.

Your data will be retained for seven years as required by the university and research bodies. After this period data held in paper format will be shredded and that held electronically deleted from the NHS LAN.

If you join the study, some parts the data collected for the study may be looked at by representatives of regulatory authorities and by authorised people from (the Trust, and other NHS bodies) to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and nothing that could reveal your identity will be disclosed outside the research site.

What will happen to the results of the study?

As part of my doctorate requirement the results of the study will be written up in the form of a dissertation report. It is also expected that the results will be written up and submitted to relevant peer reviewed journals for publication.

As is normal with qualitative research reports, findings are grounded with examples therefore excerpts from your data may be included. Care will be taken that nothing that is entered on these reports will identify you. My approach will be tactful and I will be mindful of professional, employee/employer and inter disciplinary sensitivities. I am aware of the issues related to public confidence in the NHS and NHS employees standing, and will endeavour to ensure that nothing is disseminated into a public arena which may jeopardize these.

If you would like to receive a copy of these reports please indicate this on your Participant Data Questionnaire.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS by the Lothian Research Ethics Committee and by the QMUC Ethics Board.

If you decide to participate please:

- ***complete the Participant Data Sheet which accompanies this information sheet,***
- ***complete and sign <u>two copies</u> of the following consent form,***
- ***keep one copy of the signed consent form for your own records, and***
- ***send the 2nd copy along with the completed participants information sheet via the NHS internal mail to me at the address below.***

Lloyd Wallace
Health Psychologist in Training
Dept of Clinical Psychology
Astley Anslie Hospital
133 Grange Loan
Edinburgh, EH9 2HL

***You may contact me via email address Lloyd.Wallace@lpct.scot.nhs.uk or by telephone on* 0131-537-9141**

Finally I wish to thank you for considering taking part and taking time to read this information sheet

Lloyd Wallace
Health Psychologist in Training

Queen Margaret University College
EDINBURGH

NHS
Lothian

CONSENT FORM

Participant's Identification Number (to be completed by researcher):
Title of Project: Learning and Experiencing Motivational Interviewing (MI) and Methods of Health Behaviour Change (HBC)- A Qualitative Exploration
Name of Researcher: Lloyd Wallace
Please initial box

1. I confirm that I have read and understand the information sheet **dated …./…./…….. (version .....)** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
3. I understand that data collected during the study may be looked at by responsible individuals from [regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
4. I give permission for data that I provide to be quoted verbatim in reports produced from the study	☐
5. I agree to take part in the above study.	☐

_____	_____	_____
Name of Participant	Date	Signature
Lloyd Wallace	28/12/2011	L Wallace
_____	_____	_____
Researcher	Date	Signature

When completed, 1 for patient; 1 for researcher site file;

2.2 Open-ended questionnaire

Queen Margaret University College
EDINBURGH

NHS Lothian

Learning and Experiencing Motivational Interviewing (MI) and Methods of Health Behaviour Change (HBC) - A Qualitative Exploration

Thank you for taking part in this research study.

Before I provide you with further instructions, I'd like to remind you about the background of the study. I hope this will help you describe your experience in a way that you believe will most contribute to the research questions

Increasingly non-psychologically trained health professionals are being trained in psychological models and are expected to become competent in psychologically informed therapeutic skills and consultation styles. However, very little research explores how these professionals manage this learning process, and how they as individuals and members of regulated professions experience this. This study aims to begin to fill this gap by exploring what individual and common experiences exist, and to begin to inform future training and research requirements in the area. Health professionals like yourself who have recently followed Motivational Interviewing (MI) or Methods of Health Behaviour Change (HBC) training programmes are invited to reflect on their learning experience and to describe this by completing the attached open-ended questionnaire. The broad research questions are:

How do non-psychologist clinicians learn and experience the use of Motivational Interviewing (MI) or Methods of Health Behaviour Change (HBC) as a consultation model?

How does learning MI change their clinical practice?

Depending on the data gathered and the emerging evidence, secondary research questions are:

How do they experience the learning process?

How can this process be hindered and/or facilitated?

How does this experience compare and contrast across:

- *Professions/Disciplines*
  i.e. consultant, physiotherapist, dietician, nurse, occupational therapist
- *Time*
- *Context i.e. in primary, secondary, tertiary care, acute and rehab settings, or across different illness treatment settings e.g. cardiac, chronic pain, & addictions*

To what degree are the electronic data collection methods used in the study appropriate for qualitative research?

Fundamentally the study is attempting to capture what changes participants perceive in themselves as a result of their involvement in the training program and how these changes come about?

Please read the attached questionnaire and take some time to reflect on the questions and your experience. Then complete the questionnaire, writing as much or as little as you feel appropriate for each question, though the more detailed your response the better. This is about your experience and how you describe it therefore there are no right or wrong answers and you should not be concerned about misspellings or incorrect grammar. Please try to consider and describe your experiences in relation to thoughts, attitudes, feelings, emotions, behaviours, activities, and social and work related interactions.

Begin by saving the questionnaire on your PC. Please type your answers within the box for each question. Should you require more space for your answers, the space for that question will expand automatically as you type. Remember to save your questionnaire frequently to reduce the risk of losing any information you have typed. When you have said all you want to say, save your questionnaire one last time, then please return it to me as an E-mail attachment.

Your contribution will be kept completely confidential. Please answer as open and honestly as you can - it does not matter if you consider your experience in a negative or a positive light - it is YOUR experience and I am interested in knowing this as it may inform future training programmes.

Please return your completed questionnaire by E-mail within two weeks to: Lloyd.Wallace@lpct.scot.nhs.uk

If you need help or wish to contact me by another means my contact details are as follows:

Lloyd Wallace
Pain Management Programme,
Dept of Clinical Psychology
133 Grange Loan
EDINBURGH EH9 2HL

Tel no: 0131-537-9141

1. **What were your feelings, thoughts and expectations about learning Motivational Interviewing (MI) or Health Behaviour Change Methods (HBC) before you commenced the training?** *(please consider any preconceptions, annoyances, hopes and fears you may have had and include these in your answer)*

2. **What thoughts and feelings did you experience when learning the skills of Motivational Interviewing (MI) or Health Behaviour Change Methods (HBC**)? *(please consider what this meant to you and how this has changed over time and include this in your answer)*

3. **How have you experienced putting Motivational Interviewing (MI) or Health Behaviour Change Methods (HBC) into practice?** *(please consider your thoughts, opinions, feelings, behaviour, and social and work related interactions and how this has changed over time and include these in your answer)*

4**. Since the Motivational Interviewing (MI) or Health Behaviour Change Methods (HBC) training, what if anything has changed in relation to ……**

a**. your clinical practice?**

b. **your thinking?**

c. **your feelings?**

d. **your relationships with colleagues, patients and others?**

5. **What helped you learn and incorporate Motivational Interviewing (MI) or Health Behaviour Change Methods (HBC) skills into your clinical practice?** *(if you are still in the process of learning or consolidating your learning please consider how you plan to do this and include these in your answer too)*

6a. **What hindrances do/did you experience in learning and incorporating Motivational Interviewing (MI) or Health Behaviour Change Methods (HBC) skills into your clinical practice?**

6b. **What would have helped your learning and experience of Motivational Interviewing (MI) or Health Behaviour Change Methods (HBC)?**

7. How has your work environment influenced your learning and practising Motivational Interviewing (MI) or Health Behaviour Change Methods (HBC)? *(please consider what influences your work context, your superiors, subordinates, colleagues, peers, patients, and others have had on your experience, and how this has changed over time and include this in your answer)*

8. **What do you consider to be of importance to this research study and/or to future Motivational Interviewing (MI) or Health Behaviour Change Methods (HBC) training programmes that hasn't been covered by your answers to the above questions?** *(to help with this question please consider and include in your answer what I should have asked you that I didn't think to ask.)*

Appendix 3: Training Programmes – Detailed Descriptions

Cardiac Training Programme

This programme was part of a cardiac rehabilitation service redesign in one NHS Trust in Scotland (Todd, 2003). The programme ran from 2004 to 2007 and was a mandatory training for all clinicians in the cardiac pathway of care. This included multidisciplinary staff from acute teams, specialist rehabilitation teams through to clinicians working in the community. Each clinician attended a two-day training course with approximately a one month interval between each training day. Mentoring and support were available on a voluntary basis on completion. In total 23 courses were executed and approximately 200 clinicians attended these. The workshops took place off site in specialist training accommodation.

The training course was accredited for degree points.

Aims of Training

The following is a direct extract from the course handbook:

- Skills and knowledge.
- To enable all staff involved in the pathway of care for cardiac patients, to meet standards set within the Cardiac Rehabilitation Redesign report.
- To provide theoretical framework for understanding how Health Beliefs and misconceptions influence outcomes and adherence to secondary prevention and rehabilitation.
- To help develop effective skills in eliciting and appropriate management of Health Beliefs and misconceptions.
- To provide a theoretical framework to enable understanding of principles of Health Behaviour change.
- To use practical methods to help develop effective skills in methods of Health Behaviour change. This will include assessing readiness to change, strategies for

joint agenda setting, negotiating readiness to change, exchanging information and advice, setting goals and dealing with resistance.

- To link theory and practice above to an understanding of the impact on psychological state and outcomes in rehabilitation.
- To provide a flexible support structure to allow staff to transfer learning and develop skills in the workplace.
- To link to the Competencies workbook developed for nurses in Cardiology.

Course content

The course content was based on the principles of Behaviour Change Counselling (BCC) which is essentially a distillation of MI principles and constructs designed for use in brief healthcare consultations (Lane et al, 2005; Rollnick et al, 1999). In a seminal publication explaining the method, BCC is described as "derived from the patient-centered method, with some principles and skills linked to the more specific subject of health behaviour change and motivational interviewing" (Rollnick et al, p.278). As such BCC can be considered as containing a subset MI skills and constructs. A more recent publication refers to these principles and methods as MI in health care (Rollnick, Miller, & Butler, 2008) which suggests that differentiating them from MI initially may have been misinformed and this publication appears to be attempting to right this oversight. For the purpose of this study the course is therefore considered as a training in MI as described by these two publications.

The following were the main topics included in the course:

- Challenges of dealing with patients following a cardiac event
- Theoretical background of MI
- The spirit of MI
- Active listing skills (OARS techniques)
- Establishing rapport
- Agenda setting
- Assessing readiness to change – assessing importance and confidence
- Health beliefs and misconceptions
- Recognizing and reducing resistance

- Optimal information exchange strategies (typical day information gathering strategy and the Elicit-Provide-Elicit model of information exchange)

Course developers and trainers

The course was developed by an experienced Clinical Psychologist with the support of a registered member of the Motivational Interviewing Network of Trainers (MINT). The clinical psychologist had extensive experience in Cardiac Rehabilitation and Pain Management, in delivering therapy using cognitive behavioural and motivational interviewing principles, and in providing supervision and training to psychologists and other professionals. The training workshops were run by the clinical psychologist with occasional assistance from other psychologists in training, the current researcher being one of these. Additional course support and supervision was provided by the trainer and the clinical psychologist who provided questionnaire responses from this orientation.

Course Format and Methods

A course handbook was provided.

The course took place over two one-day workshops lasting 6 hours each, with an interval of between 1-2 months between each. Teaching methods included brief lectures using slide presentations, video recorded demonstrations, discussion, small group exercises and role plays.

Each trainee undertook an audio recording of a 7-minute simulated patient consultation on the first training day. This comprised the psychologist who was assisting, role playing a resistant patient with each trainee. The current researcher performed this role play on around 50% of the training courses. The clinician's BCC skills during the consultation were rated loosely based upon a standardized scale, the Behaviour Change Counselling Index (BECCI) (Lane et al, 2005). Soon after the initial workshop, the trainees were provided individual written feedback and suggestions for areas to work on between workshops.

During the interval between worksshops trainees were expected to work on the development of skills using feedback and suggestions made in relation to the role-play

exercise, and to record details of two consultations using guidance in their workbook. In addition, participants were expected to use resource material to supplement learning. Textbooks, including Rollnick et al's (1999) main BCC text, and journal articles were made available to all trainees at local health service sites.

Assessment

To assess skill attainment, participants were asked to complete within one month of the second training workshop, a minimum of one 'work experience logbook' of contact with a patient where they had had an opportunity to address health beliefs, health behaviour change or associated psychological issues. These may have been relatively brief contacts. This logbook served as evidence of reflective practice on skill development, strategies used and perceived outcomes.

Written comments and feedback on progress was sent to participants. Skill was assessed using the BECCI scale as guidance. Participants were also encouraged to audio record this consultation for personal reflection.

To assess knowledge attainment, a short multiple-choice test was given at the end of the second training day to measure participants' knowledge of the information and associated reading covered in the course.

The criteria for interpreting scores on these measures were as follows:

Attained Competence with 'Merit'

- Strong evidence from work experience logbook records of effective use of skills and strategies taught in training - defined as meeting criteria for high skill rating on standardized measure of the BECCI. Clear and consistent identification of the role of health beliefs and psychological state as likely to influence outcome and addressed in consultation.
- Score of 65% or more on multiple choice test.

Attained Competence with 'Pass'

- Evidence from work experience logbook records of reasonably effective use of skills and strategies taught in training - defined as meeting most criteria for skilled rating on standardized measure of the BECCI. Reasonable

identification of the role of health beliefs and psychological state as likely to influence outcome and addressed in consultation.

- Score of 55-65% on multiple choice test

Although statistics are not available for all clinicians who attended the course, based on 172 trainees, 62% completed the 'work experience logbook'. Fifty six percent of these were marked as attaining competence with 'merit' and 43% with 'pass'. One percent failed and attained a pass on resubmission. Sixty-six percent of trainees completed the multiple choice test with an average score of 74%.

Follow up

Face to face and telephone supervision and support was offered. This was provided on request by the trainer and the second clinical psychologist discussed above. An intranet based electronic information and support forum was also developed and made available.

Case discussion meetings were made available on a voluntary basis to the multidisciplinary specialist rehabilitation teams. Follow-up training workshops dealing with specific aspect of MI were also provided to these clinicians. These workshops utilized a variety of methods including formal teaching, video demonstrations and role play. They addressed issues including that consultations had become too patient-led, that clinicians were concerned about MI style being unnecessarily intrusive, and how to manage patients who required specialist psychological help.

Many of the issues addressed in the follow-up training are present in the responses provided on questionnaires for the current study. Although data on whether or not participants had experienced this follow-up training was not gathered during the study, several of the participants are nevertheless likely to have received this follow-up support and training.

Substance Misuse Training Programme

This programme was part of a training endeavor in the Substance Misuse Service (SMS) in the same NHS trust in Scotland which ran throughout the second half of 2006. The

training was attended on a voluntary basis. The course comprised three one-day workshops with weekly intervals between each. In total 6 courses were run with 57 clinicians attending these. The workshops took place off site in specialist training accommodation.

Aims of Training

The following is based on the course aims described in the course handbook:

- Increase awareness of MI as a way of working with clients
- Increase knowledge of the basic principled of MI
- Increase skills in the use of MI strategies in work settings

Course content

The course delivered an MI training which was systematic and based on 'best MI training practice'. MI training literature available in Miller and Rollnick (2002), on the MI website (www.motivationalinterviewing.org), and other materials available through Motivational Interviewing Network of Trainers (MINT) was consulted and utilized in developing the course.

The following were the main topics included in the course:

- The challenges of helping people change
- Traditional approaches to helping people change
- The foundations and theory of MI
- Fundamental skills of MI (OARS techniques)
- Eliciting & responding to change talk
- Recognising & responding to resistance
- Developing a plan for change

Course designers and trainers

The course was developed and delivered by two of the SMS staff. Both had knowledge and experience of applying MI and of training others in MI. One, a Community Psychiatric Nurse was a registered MINT member. The second, was a Clinical Psychologist working in a harm reduction team who was an experienced MI practitioner

and CBT therapist, with experience of delivering MI training within the SMS and other areas of health psychology.

Course Format and Methods

A course handbook was provided.

The course took place over three one-day workshops lasting 6½ hours each, with an interval of 1 week between each. Teaching methods included brief lectures using slide presentations, live and video recorded demonstrations, discussion, small group exercises and role plays.

Between workshops trainees were requested to practice and apply the MI knowledge and skills acquired during the training workshop in their clinical work, and to complete a reflective account of a patient interaction. To encourage and facilitate this, several blank templates of a reflective diary were supplied in the course handbook. The first hour of the second and third workshops was used discuss and reflect upon trainees' experiences.

Assessment

Skill attainment was measured using the Video Assessment of Simulated Encounters-R (VASE-R) (Rosengren et al, 2005, 2008). The evaluation of the training was ongoing at the time of writing and the final results had not been published. Nevertheless pre and post training comparisons suggest significant improvement in subscale and overall VASE-R scores with an increase of 32.4% of the number of participants assessed as reaching MI competency. Although further testing has since been performed (Rosengren et al, 2008) a systematic review questioned the psychometric properties of the VASE-R (Wallace and Turner, 2009) and skills of the trainees at the time of data collection should be viewed cautiously.

Follow up

Supervision, mentoring and support were available on a voluntary basis on completion of the programme. MI practice groups have since been set up and these have had a 38% uptake. None of these support mechanisms had commenced at the time of data collection.

Appendix 4: Subsidiary Findings

4.1 Themes relating to participants' experiences of research process

This section discusses the themes that resulted from the final question posed to participants enquiring about their experience of the research process.

As evidenced already in the themes relating to reflection, participation in the current study was a positive experience for participants. Mostly it was reported that participation resulted in reflection which consolidated and restarted their learning process.

> *Although aware of it purpose as i was completing it, I didn't consider it so much as a questionnaire to be part of a study but more as a method of reflecting on my experiences. It has given me the opportunity to think again about my experiences of MI from my early days practising the techniques to the present where I feel I have a deeper insight to how I use them. It has also enabled me to consolidate my views on MI*
> (QNU02)

The diary participants echo this but add that writing the diary leads to deeper reflection which leads to better understanding which is then discussed with peers. These replies also further elaborate the benefits of keeping a reflective diary.

> *Taking part in this study has given me the discipline to formally do something that I already do in my head but never get round to writing down. While I do feel I reflect on my practice I don't write it down and I think that committing it to paper (or PC) and reading it over makes me analyze it more and perhaps make more sense of it. Additionally it has helped me reflect on learning a new skill which has resulted in me talking about it more to colleagues and made me realize how interesting other people find this topic (either my interpretation of it or how i have put it into practice). I believe that other than feeling some pressure (largely exerted by myself) to fulfill my commitment as part of a busy workload this experience was entirely positive for me.*

(DNU05)

The following extract additionally elaborates on how reflection facilitates learning, encourages, and helps manage and maintain self-esteem and professional identity.

> *I can really only think of positive effects from taking part in the study. It definitely made me think and reflect more than i would have had i not been involved in the study. It was also in a way quite therapeutic to put your thoughts down on paper, especially if you perhaps thought you hadn't handled a situation as well as you could off as when you think about more, then in actual fact it didn't seem as bad as you first though (hope that last comment makes some sort of sense??) And whilst reflecting over a scenario things certainly were clearer. thus, learning for the next time!*
> (DNU04)

The majority of participants who replied to the follow up question reported no negative effects. However two participants found the questionnaire format raised uncertainty in relation to the amount of information to provide, and stated that a face-to-face interaction would have been preferable.

> *There isn't really anything negative but I suppose with any questionnaire, it's hard to know if I'm providing enough information. With a verbal questionnaire the person can ask you to expand on certain points / clarify points.*
> (QOT09)

While acknowledging the importance and benefits of reflective practice one diary participant reported that keeping her diary was at times burdensome.

> *Positive: highlighted the importance and made me appreciate the power of reflective practice.*
>
> *Negative: it was time consuming and sometimes difficult if I didn't have anything to say.*
> (DPA02)

The following diary participant reported that the importance of keeping her reflective diary diminished as her caseload grew and as her MI skills developed

> *-ve - after time when my case load picked up it became more of a "time issue". Also, as my skills were improving over time through experience, the importance of the exercise diminished, therefore I made less and less time for it*
> (DPH01)

4.2 Findings from deviant case analysis

This participant came to her course like others with enthusiasm and positive expectations to learn a new consultation style and like others was concerned about the role plays. This concern is stronger in this case however using words like ‘put off’ to describe this experience. The case also contained themes about concern about others judging her performance and the workload involved in the training. This concern for workload was only present in one other case.

> *At the same time I was apprehensive at the work to be completed. My colleague had talked about taped interviews from a previous course and this had put me off. It can be revelation to yourself – about feeling vulnerable when others are analysing your efforts. Also the thought of practicing in front of others and listening to your consultations is embarrassing even although you know it is good to strengthen practice by being honest with yourself. Writing this sounds very selfish when the purpose is for the client to get a good and purposeful meeting but these were the feelings and thoughts that were uppermost – vulnerability, embarrassment, nervous about revealing weaknesses, comparing myself against other colleagues from different professions, wondering what was in store, how quickly we had to practice skills etc. The thought too of the assignments was at times overwhelming, asking clients to be taped and having the time to transcribe the tapes seemed like a lot of extra work.*
> (QDI21)

This clinician reported that she did not utilize supervision. She reported difficulty setting agendas and appears to have allowed the client's agenda to direct consultations. As discussed previously this issue is mentioned by many other participants and by the psychologist who supervised many trainees. Through supervision, peer discussion and other structured reflection methods, trainees come to learn that they could be more directive in setting consultation agendas. The difference in this deviant case is that this issue is described in terms of problematic patients and timing, whereas it may be more to do with the same skill deficiency and non recognition of MI principles described by the other participants.

> *Of course starting where the client is, is the hardest thing. They set the agenda and may not wish to have any of the information you have lined up – so the hindrance would be using the strategies appropriately and knowing when to use them timely.*
> (QDI21)

As with many others the deviant case feels deskilled when she begins to practice exercises but she uses stronger emotion, 'shock', to describe this experience.

> *This came as a shock really as I thought that I was fairly client centered*
> (QDI21)

QDI21 refers to the MI methods as 'CBT' which is a misnomer which may lead her to believe that she has completed a Cognitive Behavioural Therapy training, which she has not. This could be problematic in that she thinks she is learning CBT and this could inoculate against attending future CBT courses

QDI21 does not recognize that appropriate information giving and information exchange is advocated by MI methods resulting in a perception or belief that she is not managing to practice MI appropriately. Had supervision been utilized, perhaps this misconception could have been reflected upon and realigned appropriately.

> *During the consultation he asked me several questions about his health as he was clearly worried about things he had gathered from his family. I found it difficult to keep to CBT style as I felt I had to answer his questions as factually as I could. However, the questions gave me some idea as to his fears*

> *and I thought by answering them the resistance would reduce. I also felt during the interview that I should be imparting more facts to enable him to consider the dangers of his behaviour. This was difficult for me not to do and again highlighted the unlearning that has to go on in order to make the consultation meaningful for the client.*
> (QDI21)

She frequently referred to the lack of opportunity to practice with appropriate clients to explain either why she had no opinion on how her practice had changed, or why her practice had not changed in the way she had hoped. She also provided this as a reason for not utilizing supervision, an important facilitator according to other trainees. She does not see MI methods as having any practical relevance to group work or to another clinical setting. This may be true, but it could also be due to her non recognition of opportunities to use MI in other contexts or in anything other than 1-to-1 consultations.

> *I have had a limited chance to use CBT. Our project focus moved away from 1-1 consultation to training and group work shortly after the course and my other client group are adults with a learning disability.*
> (QDI21)

> *As I have had few one to one clients to practice on since the training I could not say.*
> (QDI21)

> *By having more clients to practice on which would then have meant I would have looked towards supervision and used the website.*
> (QDI21)

QDI21's questionnaire contained several references to disappointment as MI methods resonated with her. This experience of not learning MI due to lack of opportunity to practice and access to appropriate clients highlights the need for appropriate clients and reflection processes to be available relatively soon after training in order to develop MI skills and to become aware of this development while enthusiasm and motivation to practice is high.

> *I feel very positive towards CBT and am aware that the method will only become easier if practised routinely and embodied as part of the treatment.*
> (QDI21)

QDI21's text contains frequent themes of disappointment in her progress and sometimes in herself for not managing to progress further, perhaps through utilizing opportunities for structured reflective practices.

> *I guess for me the lack of opportunity due to change in work practice has hampered my progress and so I would have liked to stay on track with this.*
> (QDI21)

> *I guess that is the nature of courses – it needs a lot of personal responsibility to keep engaging if conditions change*
> (QDI21)

> *Perhaps with the absence of clients, it may have been possible to shadow others during consultation or to have set up some dummy consultations to practice the methods.*
> (QDI21)

Although this deviant case contrasts with other clinicians' experiences, on closer consideration, it in fact illustrates what may happen when appropriate opportunity to practice and reflect is not available. In so doing it triangulates and strengthens the validity of the findings already discussed relating to how supervision and reflection facilitate and consolidate learning.

Appendix 5: Demographic Data for Questionnaire Participants

Demographic Data for Questionnaire Participants

	Course Setting		
Course Setting	**Cardiac**	**Substance Misuse**	**Total**
No. of Participants	13	5	18
Gender			
Female	11	4	15
Male	2	1	3
Profession			
Nursing	4	2	6
Dietetics	2	-	2
Physiotherapy	3	-	3
Medicine	2	1	3
Occupational Therapy	1	-	1
Psychology	1	1	2
Generic mental health worker	-	1	1
Years in profession			
Min	3½	6	3½
Max	26	28	28
Mean	14	15	11
Employment			
Full Time	7	5	12
Part Time	6	-	6
Age			
<20	-	-	-
21-25	1	-	1
26-35	3	3	6
36-45	8	-	8
46-55	1	2	3
55(6)	-	-	-
Education			
Doctoral	2	1	3
Post Graduate Degree	3	1	4
Post Graduate Diploma	-	1	1
Degree	7	2	9
Diploma	1	-	1
Previous Training			
MI	2	2	4
Counselling	-	3	3
CBT	1	2	3
Time since MI training			
Min	4 months	4 months	4 months
Max	3 years	10 months	3 years
Mean	19 months	7 months	16 months

	Course Setting		
Course Setting	**Cardiac**	**Substance Misuse**	**Total**
Supervision utilized	7	1	8
Supervision Format			
face-to-face	6	1	7
telephone	1	-	1
web forum	1	-	1
peer	3	-	3
E-mail	1	-	1
Ind. or Group Supervision			
Individual	2	1	3
Group	3	-	-
Both	2	-	-
Supervision Frequency			
weekly	-	1	1
fortnightly	1	-	1
monthly	1	-	1
two monthly	1	-	1
when required	4	-	4
Patient Group			
cardiac	11	-	11
substance abuse	-	5	5
other	2	-	2
(multiple setting)	(2)	(1)	(3)
TreatmentMode			
individual	6	4	10
group	-	-	-
both	7	1	1
Treatment Setting			
acute	2	-	2
community/primary care	5	4	9
rehab	5	-	5
mixed (rehab/community)	1	1	2
Average Consultation Duration			
Min	15 mins	30mins	15mins
Max	90 mins	60 mins	90 mins

Appendix 6: Participant Reference No. coding format

The Participant Reference No. assigned to each participant in order to anonymize their data, and used in this report to identify participants' citations were coded using the following algorithm:

Participant Identifier No. = 'xppnn' where:

x = 'Q' or 'D' signifying whether the participant completed a questionnaire (Q) or a reflective diary (D).

pp = 'DI' when the participant was a dietician
'DR' when the participant was a medical consultant or registrar
'GM' when the participant identified themselves as a general mental health professional
'GP' when the participant was a general practitioner (GP)
'NU' when the participant was a nurse
'PA' when the participant was an assistant psychologist
'PH' when the participant was a physiotherapist
'PS' when the participant was a chartered clinical psychologist, or a trainee clinical psychologist
'OT' when the participant was an occupational therapist

nn = a sequential number assigned within questionnaire or reflective diary participants

For example:

Participant Reference No. QDI06 signifies the 6th Questionnaire participant, and who identified as a dietician.

Appendix 7: Recommendations for MI training programmes

1. Training should be marketed to prospective trainees in ways that inform them of the benefits they and their patients may gain from the training, and that increase their perceived need to learn.

2. In an effort to minimize the impact of the compromised professional identity and negative emotions that those learning MI might experience, it could be useful to inform prospective trainees about the proposed 8 stages of learning MI, and the challenging nature of learning MI, thus setting realistic expectations and helping them better negotiate this transition.

3. Appropriate mentoring and supervision with protected time should be available for trainees. The benefits of supervision and what it entails should be explicitly explained to trainees to encourage uptake of the types of support that are necessary to learn MI.

4. Some training on asking about sensitive issues and managing sensitive disclosure should be provided as part of training. Onward referral pathways and emotional support should be made explicit and available if trainees are to fully embrace the MI mtethods.

5. Opportunity to practice MI with real clients should be ensured soon after completion of training workshops.

6. Training on how to perform and utilise reflective practices (including reflective diaries) for facilitating learning should be part of MI training programmes. Participants should be informed of the positive experiences of others who completed reflective diaries to encourage their use during training.

7. A reduction in confidence might be a valid post workshop outcome.

8. MI skill and competency outcomes may not be available or measurable until sometime after initial training.

9. Wherever possible entire teams should be trained in the approach and new staff joining teams who use the approach should be trained as soon as possible.

10. Training should explain that a more authoritarian/expert approach may be more appropriate for some patients e.g. when their self-efficacy or understanding is low.

11. Where possible training should include what is known about the factors that influence behaviour and illness in specific contexts and populations and findings from health psychology studies relating to health behaviour models may inform this

Appendix 8: Suggestions for future research

1. What is the utility of open-ended questionnaires such as the one used in the current study in facilitating reflection and learning MI?

2. If using reflective diaries, be specific about what should be written about, and stipulate how often this should be done. Encourage more conscientious completion of diaries by being more proactive in collecting journal data, and inform participants to expect reminders,

3. Can culture change theories contribute to the development and dissemination of MI practices and MI training?

4. Is juxtaposition tenable of stages 3 and 4 of the Four Stages of Adult Learning model for some skills, and in particular therapeutic skills?

5. Whether MI training leads to decreased stress and burnout, and increased job satisfaction should explored. Additionally whether training entire teams in MI results in increased team effectiveness and improved teamwork should be explored.

6. How can the models and theories developed in relation to CBT training inform the research and theory relating to MI training and learning.?

7. How can Health Behaviour models inform the research and theory relating to MI?